DOCUMENT RESUME

ED 477 919 CG 032 301

AUTHOR	Eschbach, LeeAnn, Ed.; Carey, Andy, Ed.
TITLE	The Journal of the Pennsylvania Counseling Association, Volume 5, 2003.
INSTITUTION	Scranton Univ., PA. Pennsylvania Counseling Association.
ISSN	ISSN-1523-987X
PUB DATE	2003-00-00
NOTE	97p.
AVAILABLE FROM	Univ. of Scranton, Pennsylvania Counseling Assoc., Counseling and Human Services Dept., Scranton, PA 18510-4523.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Journal of the Pennsylvania Counseling Association; v5 2003
EDRS PRICE	EDRS Price MF01/PC04 Plus Postage.
DESCRIPTORS	*Competence; *Counseling; Counseling Techniques; *Counselor Supervision; Counselor Training; *Cultural Awareness; School Counselors; *Vocational Rehabilitation
IDENTIFIERS	Countertransference; Multicultural Counseling

ABSTRACT

This document consists of the two issues making up volume 5 of "The Journal of the Pennsylvania Counseling Association." The articles attempt to meet the interests and needs of those in various counseling fields by exploring many diverse counseling issues and counseling approaches, and discussion of current counseling topics. Articles in the first issue include: "Multicultural Counseling Competencies in the 21st Century: Are Vocational Rehabilitation Counselors Primed for the Next Millennium?" (Keith B. Wilson, Michele L. Henry, Carmenlita D. Sayles, Julissa Senices, and Donald R. Smith, Jr.); and "Countertransference and the Hidden Client in Counselor Training and Supervision" (David J. Tobin). This issue concludes with a sampling of PCA conference program abstracts. Articles in the second issue include: "Promoting Cultural Competence in School Counselors" (John McCarthy and Angelina T. Santus); "A Comparison between African Americans and European Americans in the Vocational Rehabilitation System after the Initiation of the Individual Plan for Employment (IPE): Are there Really Differences?" (Keith B. Wilson); and "Campus Wide Alcohol Use Compared to Students Seeking Services" (Donald A. Strano, Riley H. Venable, and Jason L. Charney). (Contains 169 references.) (GCP)

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The Journal of the Pennsylvania Counseling Association

Volume 5, Numbers 1 & 2
2003

LeeAnn Eschbach and
Andy Carey,
Editors

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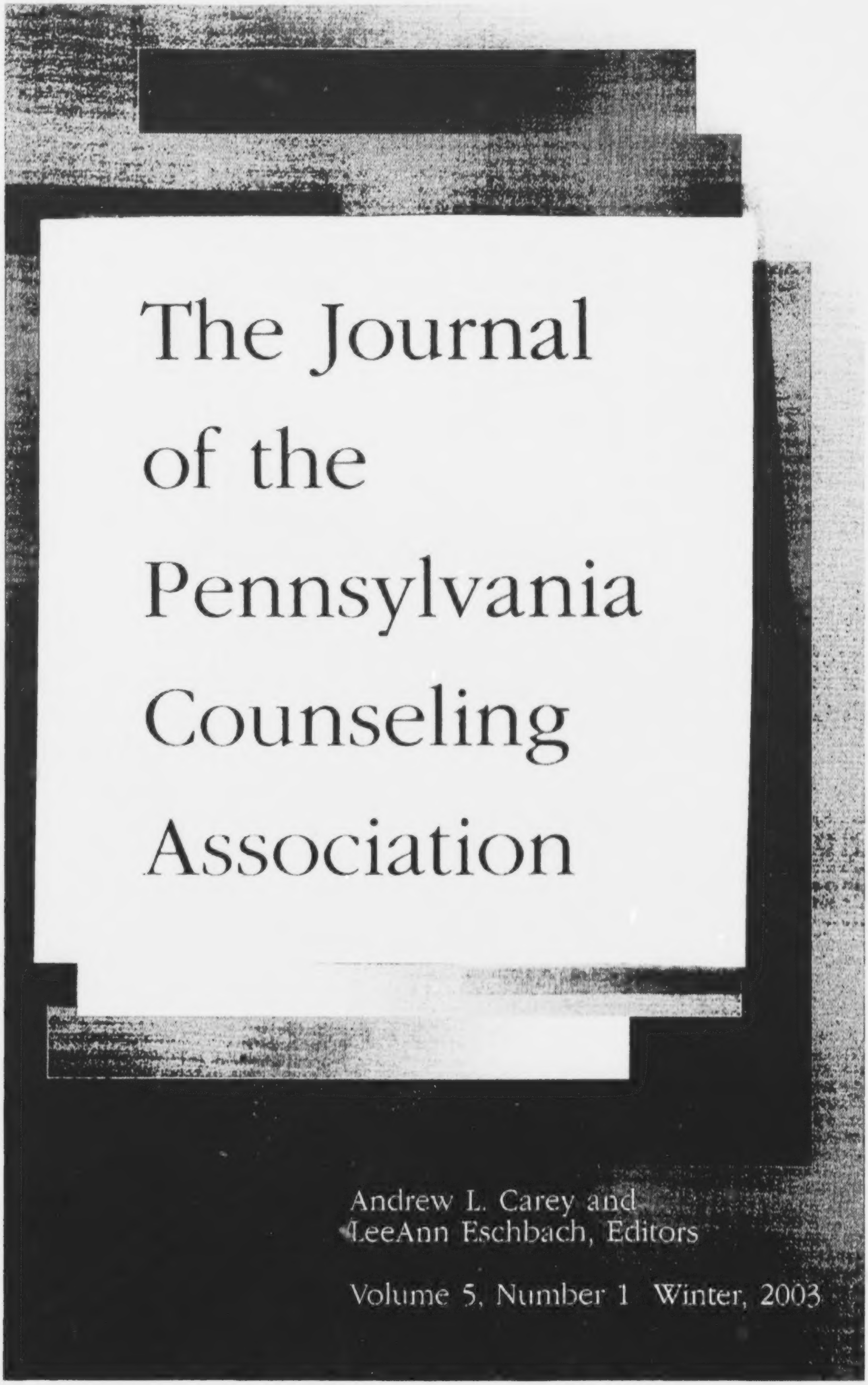

The Journal of the Pennsylvania Counseling Association

Andrew L. Carey and
LeeAnn Eschbach, Editors

Volume 5, Number 1 Winter, 2003

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Cover Design and Graphics: Kurt L. Kraus, Assistant Professor, Shippensburg University, Shippensburg, PA. Special thanks to Johanna Jones for the typeset.

Winter 2003 *Volume 5, Number 1*

The Journal of the Pennsylvania Counseling Association

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 Winter 2003

Change and Commitment

LeeAnn Eschbach and Andy Carey

As professional counselors in Pennsylvania, members of the *Pennsylvania Counseling* Association practice counseling in diverse settings. Regardless of our work environment, whether we practice counseling in a school, agency, hospital or private practice, two common elements we all share as professional counselors in Pennsylvania are change and commitment.

This issue of the *Journal of the Pennsylvania Counseling Association* goes to press as we experience changes in the seasons. We look at the uniqueness of each season and just as nature continues to unfold and change, so must we as professional counselors. It is our hope that professional counselors in Pennsylvania can embrace change and participate in activities facilitating self-growth just as we embrace the newness of each season in nature.

Change may mean stretching ourselves both professionally and personally in different and possibly new directions. Professional counselors are more effective when they are self-aware and able to use themselves as instruments through which change occurs (Norcross, Strausser, & Missar, 1988). Thus, we need to open ourselves to the possibilities associated with change. Change may mean taking the time for expanding our self-awareness through self-reflection, self-assessment, and self-evaluation of our professional work. Self-awareness facilitates our receptiveness to suggestions for change that are needed to maximize our therapeutic effectiveness (Sharf, 2000). Change may mean embracing continuous learning. This could be operationalized by setting goals for new areas of professional learning. Understanding, analyzing, investigating and implementing new perspectives and innovations in the counseling field are hallmarks of successful and effective professional counselors. Change may mean reassessing the current needs of our clients. Perhaps we need to shift the lens through which we view clients' presenting problems. This mandates our openness to learning new information and techniques as we are confronted with new client populations and new client issues and concerns.

When we made a commitment to the counseling profession, we made a commitment to facilitate human development and adjustment throughout the lifespan. We made a commitment to serve clients, nurture clients, facilitate clients' coping with their unique life challenges and foster clients' growth and changes. We made a commitment to the professional responsibility articulated in the American Counseling Association Code of Ethics and Standards of Practice (1995). This includes continuing our learning, training, and implementing new approaches under supervision.

As we review new information, strategies and approaches in the counseling field, we need to consider how to integrate this into our professional counseling work. How will this information facilitate our own self-growth? How can we apply new information on counseling approaches to our work with our unique clients? What clues do we search for to ascertain client needs? How do we decide what techniques and approaches are relevant for our clients? How can we integrate proven counseling concepts and techniques to help clients function better? How can we update our counseling work and insure our approaches are legally and ethically appropriate? What topics do we need to investigate for our own continuous learning as professional counselors?

This issue of the *Journal of the Pennsylvania Counseling Association* provides opportunities for continued learning and self-growth. This issue shares many diverse counseling issues, counseling approaches and discussions of current counseling topics. Topics range from art therapy to multicultural counseling, working in rehabilitation, college and school counseling settings, as well as counselor preparation and supervision issues. This issue also presents several abstracts from the *Fall 2002 Pennsylvania Counseling Association Conference Valuing Commitment*. Our hope is that the articles in this issue provide a motivator for your continued learning as a professional counselor and an opportunity for you to broaden your horizons of self-growth and change.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 Winter 2003

Multicultural Counseling Competencies in the 21st Century: Are Vocational Rehabilitation Counselors Primed for the next Millennium?

Keith B. Wilson
Michele L. Henry
Carmenlita D. Sayles
Julissa Senices
Donald R. Smith Jr

The purpose of this manuscript was to examine the epigrammatic literature concerning counselor competencies in the area of multicultural counseling. This paper concludes by looking at the counseling field today, and what might be done to improve counselor competencies, thereby facilitating positive experiences for culturally diverse populations in the area of vocational rehabilitation counseling in particular, and the human services, in general

Introduction

Religion, nationality, family, beliefs, and customs are all variables necessary for consideration when one looks at our increasing diverse population. In addition, people from diverse sociocultural backgrounds, because of their different values and beliefs, tend to define health and illness differently and to attribute the cause of their mental health to many factors. In support of the diversity of values, Chiu (1996) reported that people from different cultures have similar psychiatric problems, which may be manifested differently than the majority culture. Accordingly, counselors need to understand a person's cultural beliefs and customs in order to avoid misdiagnosis of psychiatric problems. As our population diversity will no doubt continue well into the Twenty-first Century, counselors will be faced with increased diagnostic and treatment problems that will create additional barriers to supporting diverse populations. Treatment strategies may become as varied as the cultural backgrounds of clients, as no one treatment will suffice for all clients. It is adduced through ongoing educational activities and field experiences that mental health professionals are adequately prepared to diagnose and treat a diverse population. However, current implementation of in-service and curriculum advances serve as a minor reflection of what the counseling field needs in this vital service area. Vocational Rehabilitation (VR) counselors and mental health professionals need to understand and accept each cultural group's idiosyncrasies, identity, and background in order to provide effective treatment. Moreover, it seems to elucidate the need for counselor competency as we move into the next millennium. Lastly, the implications for VR are magnified when one considers that racial minorities tend to have higher rates of disability than individuals from the majority group (Hayes-Bautista, 1992; National Institute on Disability and Rehabilitation Research (NIDRR), 1992; Smart & Smart, 1997).

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As the higher rates of disability among racial minorities increase, it is likely that VR counselors will see an increased number of clients seeking VR services who look and sound differently than White American clients. To reinforce this point, Pope-Davis and Ottavi (1994) assert that minority counselors, because of similar experiences, more effectively address the needs of racial minority clients.

Multicultural Expansion

Multicultural expansion is not only a concern that VR counselors will face in the coming years, but also a global transformation likely to touch many human service professionals not only in VR, but in the areas of social work and psychology as well. "The reason that mental health professionals in nations around the globe have been increasingly confronted by an unprecedented number of foreign patients during the past several decades is the rapid growth of worldwide population migration" (Chiu, 1996, p. 130). This population migration is the result of several factors, including the reduced cost of international travel and the spread of multinational companies around the world, causing millions of workers to reside in foreign countries for long periods of time. Other factors affecting population migration have included discordance in the Soviet Union and Germany, and refugee problems in places such as Africa and Eastern Europe (Chiu, 1996). It is anticipated that the growth of the international populace will continue well into the next century, potentially producing more foreigners seeking US citizenship. As a result, the growing numbers of refugees, for example, will increase the possibility that VR counselors, and other professionals, will see many more racial and ethnic minority clients who seek VR services. One can already observe the influence of the demographic transformation. For example, Sue, Arredondo, and McDavis (1992) reported that by the year 2010, racial and ethnic minorities will become a numerical majority in many places. "The extent of the U. S. multicultural society and the role it plays in shaping people's lives will continue to become apparent to counseling professionals as increasing numbers of clients from diverse cultures seek mental health services" (Baruth & Manning, p. 4, 2003). Given the current demography, working with minority clients will be the norm rather than the exception in the human services (i.e., mental health and vocational rehabilitation agencies). People in every nation have serious mental and emotional problems and studies show that immigrants have a higher rate of mental and emotional concerns compared with those who stayed in their homelands (Chiu, 1996). Perhaps, U.S. counselors tend to attribute mental illness to immigrants because counselors in the U. S. lack specific multicultural training to diagnose potential mental health problems of immigrants. Due to the current demographic changes in the U.S., counselors must modify their views and approaches to clients who look and behave differently from themselves. Therefore, current counselor training programs should coincide with current demography and include more minorities and staff members, to increase the possibility of initial rapport between the client and the counselor.

In addition to population migration, higher birthrates among minorities have also contributed to the diversity of the U.S. population (Aponte & Crouch, 1995). Although both African Americans and White Americans are experiencing a decline in birthrates, the birth rates for White Americans are dawdling more than African Americans. For example, birthrates for both African Americans and Mexican Americans are twice that of White Americans in the United States. In addition, compared to White

Americans, Asian Americans have birthrates from three to ten times higher (Sue et al., 1992). It is apparent that migration and higher birthrates of minorities account for some of the proliferation in the demographic transformation in the United States.

This combination of population migration and high birthrates, and the resultant increase in the multicultural population has enhanced the attention given to the existence and treatment of psychological disorders in a diverse society (Chiu, 1996). Counselors and teachers have already encountered these demographic dynamics in work milieus throughout the U.S. Therefore, to be fully competent in working with racial and ethnic minority populations, it is important for the counseling profession to incorporate standards of practice and training that reflect the diversity of our society (Sue et al., 1992). It is widely known that counselors in different cultural settings can diagnose the same problem differently, depending on their own backgrounds and those of their clients. Thus, it is imperative that rehabilitation counselors and other mental health professionals are cognizant of culture in diagnosing and treating mental and emotional disorders (Chiu, 1996). Because stereotypes can lead counselors to presume conclusions and make unsound postulations about their clients (Rosenthal & Kosciulek, 1996; Sue et al., 1992), being aware of one's own biases is a critical first step in assisting minorities through the human service system. Based on one's race, experiences, and cultural background, the interdependency of the counselor-client relationship is undeniable on several affective and cognitive levels.

Multicultural Counseling Competencies

It is apparent that multicultural counseling competencies are fast becoming tools that VR counselors are utilizing with an increasingly expanding clientele. It is within this context that "in recent years, concerns about the mental health needs of multicultural clients have been heightened" (Pope-Davis & Ottavi, 1994, p. 651). The 1993 ethical guidelines of the American Psychological Association required multicultural competencies of all counselors. To date, optimally effective methods for improving multicultural competency have not been easily accessed (Pope-Davis & Ottavi, 1994). Prior research on counseling theories has delineated the particular skills, attitudes, and beliefs necessary in order to be considered an effective counselor with majority clients (Cormier & Cormier, 1991; Giles, 1993). "Traditional counseling methods have failed to adequately consider the importance of race, culture, and ethnicity in the counseling process" (Sue, 1996, p. 279). Thus, a counselor's training and education must be adapted if we are to produce mental health professionals skilled in addressing and assessing the needs of our growing multicultural clientele. Although the National Council of Teacher Education (NCATE) and the Council of Accreditation of Counseling and Related Education Programs (CACREP) have adopted that multicultural education should be a part of counselor education programs (Baruth & Manning, 2003), because there are divergent views on what multicultural education is and is not, many authors (e.g., Banks, 1991,1997; Bennett, 1995) infer that multicultural education was often treated as ancillary and not an integral part of the curriculum in our school system across the United States. Sue (1996) reported that "if we truly believe that multicultural competence is important, then graduate programs must be able to teach and measure it" (p. 281). It is excruciatingly obvious that there is a need to "develop new models, methods, and actions to aid us on the road to multiculturalism" (Sue, 1996, p. 283). For instance, it is common knowledge that traditional counseling models, which emphasize a westernized philosophy of counseling (*Eurofocused*), have been ineffective in serving a diverse population. Therefore, it is necessary to develop models that will benefit all populations in the therapeutic process (Sue & Sue, 1990; Sue et al, 1992). Conceivably, the major reason for this therapeutic ineffectiveness lies in the training of VR counselors and mental health professionals in the human services. Training is a vital part of addressing the lack of current skills in the vast number of counseling professionals who are destined to face a growing diverse clientele as we cross the threshold of a new century.

Multicultural Counseling Therapy

The study of multicultural counseling and therapy (MCT) has continued to grow and become influential in the human services. Early advocates of MCT pointed out that there was little understanding about the history, experiences, life styles, and worldviews of culturally different populations. Furthermore, counseling professionals did not take into consideration the sociopolitical realities of the clients they served. Hence, counselors are less likely to include a systematic approach to address sociopolitical issues when dealing with racial and ethnic minority clients (Sue & Sue, 1990; Sue, 1996; Wilson, Harley, McCormick, Jolivette, & Jackson, 2001). For that reason, the present authors suggest that MCT be implemented to evaluate counselor competency. Utilizing MCT will allow educators to determine the effectiveness of their training programs by enhancing the skills needed to produce graduates who are competent working with racially and ethnically diverse populations. Although not recognized earlier by many counselors, MCT continues to gain acceptance within the counseling community to access the history, experiences, life styles, and worldviews of racially and culturally diverse populations.

Counseling Minorities: Self-Empowerment

Another significant theme when counselors encounter diverse populations is the issue of self-empowerment. There are several methods and concepts counselors pursue to facilitate self-empowerment in their clients. One such approach is called a "directive approach." A directive approach is a salient method used in the process of self-empowerment. Minority counselors may be better equipped to take on such an approach because of their own background and ability to validate racial and ethnic minorities' experiences, generally. To support this assertion, Pope-Davis and Ottavi (1994) stated that, "minority counselors may, in fact, be better prepared to address the needs of ethically diverse clients, given their sociopolitical histories and personal experiences" (p. 654). It seems that many health designs emphasizing self-empowerment in order to meet the needs of a diverse population may not respond favorably to vague responses by White American counselors. According to Wilson, Jackson, and Doughty (1999), these vague responses may be indicative of the unproductive reasons for terminations for racial and ethnic minorities when compared to White American clients in the VR system. As empirically supported by several research teams, access to vocational rehabilitation services appears more complex for minorities than for White Americans in the United States (Wilson, et al., 2001; Wilson, Jackson, & Doughty, 1999). Moreover, worldview may be another potential barrier to improving empowerment among racial and ethnic minorities. To add further support to this worldview contention, Pope-Davis and Ottavi (1994), and Mahalik, Worthington, and Crump (1999) reported that therapists have a world view which tends to resemble the White middle-class in the United States, even if the counselor is African American. Notwithstanding these conceptual discrepancies in worldview, McFadden (1996) supported this debate by endorsing the stylistic counseling method. The stylistic counseling method emphasizes the integration of a client's cultural history with the traditional dimensions of counseling. McFadden purports 'stylistic counseling' as a means of self-empowering diverse populations. The stylistic counseling method maintains counselor mastery of three primary dimensions: cultural-historical, psycho-social, and scientific-ideological. By incorporating all three dimensions, counselors will acknowledge the cultural-historical component within the individual, as well as, recognize the individual differences within a cultural group. Moreover, through this assessment, the counselor can be more directive by operating in the scientific-ideological dimension of counseling. Particularly, this method supports prerequisites for effective multicultural counseling and it is geared toward counselor development in appling their knowledge and skills in counseling across cultures (McFadden, 1996).

Regarding self-empowerment of racial and ethnically diverse clients, McFadden (1996) reported that minority clients especially, might be better served by health professionals using the *stylistic counseling* method as traditional methods have missed the mark, and often minority clients are dealt with in a manner not beneficial to their progress in the "therapeutic" relationship. Baruth and Manning (2003) conclude that many counseling approaches facilitate therapeutic movement by employing general and often evasive responses during the counseling session. This traditional approach is counterproductive to some minority clients. Baruth and Manning go on to adduce that:

> Many counselors probably received their professional preparation at institutions that provided training for counseling majority-culture clients. Such training was unquestionably appropriate for counselors preparing to work with mainstream clients; however, the possible lack of training and clinical experience with clients of diverse backgrounds indicates the need for improved understanding of appropriate intervention measures. (p. 8)

Consequently, the high termination rates of racial and ethnics minorities in counseling is believed to be a result of some non-minority (White American) counselors not using appropriate empowering techniques when counseling with racial and ethnic minorities. To empirically support this contention, Sue and Sue (1990) reported that after one contact with a counselor, African Americans had a 50% termination rate compared to 30% for White Americans. Furthermore, to buttress what Sue and Sue observed ten years earlier, Wilson (2000) recently reported that White American clients are more likely to be accepted to VR when compared to African Americans with disabilities. It is reasonable to infer that the discrepancy in termination and acceptance rates between African and White Americans is possibly a multicultural issue. McFadden (1996) stated that minority clients are looking for specificity, concreteness, and conciseness, and the stylistic method allows for interaction between client and counselor to be direct and concrete. Self-empowerment for the client is a major component of many health designs developed to meet the needs of a diverse population that may not respond favorably to vague responses by White American counselors.

Another perspective on empowerment is reported by McWhirter (1991) who wrote that empowerment is a means by which clients gain mastery over their affairs. McWhirter continues:

> Empowerment is the process by which people, organizations, or groups who are powerless (a) become aware of the power dynamics at work in their life context, (b) develop the skills and capacity for gaining some reasonable control over their lives, (c) exercise this control without infringing upon the rights of others, and (d) support the empowerment of others in their community. (p.224)

She further stated that the underlying goal of many counseling interventions is to empower the client. Through empowerment, counselors attempt to help clients facilitate change, leading to greater feelings of personal control over their lives (McWhirter, 1991). "Empowerment also includes recognition of the current abilities of marginalized individuals and the development of skills that foster their increased control at interpersonal and community levels" (McWhirter, 1991, p. 223). McFadden's stylistic model is a prime example of the self-empowerment approach that is imperative to successful outcomes when working with racial and ethnic groups. As evident in past research, it is becoming increasingly important to employ counseling strategies that will increase positive therapeutic benefits for minority clients.

Counseling Racial and Ethnic Minorities and the Language Barrier

Along with his endorsement of the stylistic method of counseling for minorities, McFadden (1996) and others (e.g., Quiñones-Mayo, Wilson, & McGuire, 2000; Sue et al., 1992) adduced that the lack of bilingual therapists who can communicate with, and understand the values, lifestyles, and backgrounds of minority clients is a major reason for the inadequacy of VR and mental health services for ethnic minority groups. As already observed in certain parts of the United States, bilingualism is becoming essential for employing effective multicultural counseling abilities. Sue et al. (1992) suggested the importance of mental health professionals valuing bilingualism, as it is an expression of personal freedom and pluralism. The need for bilingual counselors seems particularly apparent when counselors assist Latino (Hispanic) clients. Language differences can also be a potential barrier that contributes to the underutilization of mental health services. To further support the importance of counselors understanding the need to adopt bilingualism, Santiago-Rivera (1995) reported that a client's initial assessment of physical and mental health can be greatly impeded by the language barrier. Thus, some mental health researchers (e.g., McFadden, 1999; Sue et al., 1992) make an argument for bilingualism and its inclusion in counseling training programs, to facilitate the therapeutic alliance between the client and the counselor. In fact, counselors may be in a double-blind dilemma when trying to treat individuals from racially and ethnically diverse backgrounds. More specifically, if counselors seek to follow the traditional counseling approaches, then they also need to consider referring clients that they cannot establish a meaningful therapeutic relationship based on multicultural issues. Because of the increased Hispanic population not only in the United States, but in the VR system, we certainly support more bilingualism training for all counselors. Depending on the part of the country, the need for bilingual training and skills may be more essential.

Advancing the bilingual training and skills assertion a step further, Santiago-Rivera (1995) reported that if counselors are not fluent in different languages, they need to ask themselves if they really understand what the client is saying, and how language is being communicated. The evaluation of physical and emotional symptoms and the design of a treatment plan are influenced by the counselor's interpretations of what the client is telling him or her in the counseling session. For example, a Latino client whose cultural beliefs, values, and customs differ from the counselor's may not only attach a different meaning to symptoms, but also express these symptoms differently, which can be easily misunderstood by a counselor not skilled in this area of multiculturalism. Another aspect contributing to the language barrier between counselor and client is that the Spanish-dominant client when speaking in English, lacks emotion (Santiago-Rivera, 1995). Speaking in the native language allows clients to remember past experiences, and the emotions associated with those experiences that would not be possible in the nonnative language (Javier, 1990). Here, positive therapeutic ramifications and implications of racial and ethnic minority clients speaking in their native-tongue seem obvious. It is apparent that allowing clients to communicate in their native-tongue may have positive therapeutic benefits that will enhance the treatment process.

Another area that can facilitate a positive experience between the counselor and client is described as 'language switching.' Language switching allows clients to switch, or alternate as needed, from native to nonnative language during therapy. Santiago-Rivera (1995) postulated that the client may be better able to express emotion in his/her native language during the language switching process. Additionally, the bilingual client struggling with emotional content may benefit from talking about painful or anxiety-provoking experiences in the nonnative language. In order to productively facilitate a counseling session with the client, the counselor will need to carefully assess how the client is using the native or nonnative language and determine the benefits of allowing the client to communicate experiences in a particular language. Furthermore, according to Santiago-Rivera (1995), the counselor should not only initiate language switching, but also provide some direction for doing so. Santiago-Rivera also suggested that considering the client's level of acculturation is an essential element in individualizing treatment. Santiago-Rivera continues:

> Language dominance, or preference, and adherence to cultural values and customs are noted here as separate factors to consider. Although there may be a high degree of correspondence between the two, it is possible for the client to maintain certain cultural values as norms such as the significance of familismo (obligation to, and support from, relatives) while having lost the ability to speak fluent Spanish. Thus, the degree of bilingualism and language preference should be assessed. (p. 15)

Although the Latino population is primarily mentioned in relationship to language barriers in many research publications, several racial and ethnic minority groups have experienced the communication barrier while in counseling (for example, people who are Asian or Haitian). As counselors continue to encounter immigrants from other foreign countries, language barriers will become increasingly prominent in the treatment of more diverse clientele. Asian cultures may be particularly difficult as they come from widely divergent cultural backgrounds ranging from fourth and fifth generations to the more recent Filipino and Vietnamese immigrants. If a VR counselor is unfamiliar with the client's culture or language, other treatment resources should be used when deemed necessary and appropriate (Santiago-Rivera, 1995). Although potentially costly and beneficial, Vasquez and Javier (1991) reported that soliciting the assistance of a well-trained bilingual interpreter can be effective in bridging the gap between the English-speaking counselor and the client whose dominant language is not English. Although being able to understand potential language barriers is vital for certain diverse populations, it is not clear whether understanding and being considerate to language barriers will produce higher retention outcomes during therapy.

Recommendations: Improving Multicultural Competency

Chiu (1996) set forth several strategies for improving multicultural competencies among mental health professionals: (a) therapists should be aware of clients' differences in verbal and nonverbal communications to prevent misunderstandings; (b) practitioners should engage in cultural self-analysis to alleviate countertransference; (c) therapists should practice taking a thorough patient history, including religious and cultural norms, beliefs and values, and economic status, especially when seeing clients whose values and understanding of health are shaped by folk culture; (d) therapists should understand other racial and ethnic minority communication patterns by reading the latest empirical and theoretical information impacting cross-cultural factors on mental health; (e) therapists should continue to consult with colleagues about the impact of sociocultural variables (e.g., gender, race, ethnicity) on mental health; and (f) educational organizations that train mental health professionals must establish more multicultural courses and workshops to heighten awareness of how different racial and ethnic and minority people experience and exhibit mental and emotional disorders. The recommendations by Chiu (1996) will assist not only VR counselors, but all counselors in developing a more global perspective in assisting people of different races and cultures during therapy.

The authors submit that there are several ways to enhance multicultural competencies in counselors. One such way is to include cultural knowledge and information into such tasks as intervention strategies, conceptualization of problems, and establishing client objectives (Sue & Zane, 1987). On this point, therapists need to confront their own belief systems while interacting with clients from other cultural backgrounds. Pedersen and Leong (1997) also adduce that knowledge vis-à-vis counseling in other countries can teach therapists new counseling strategies. However, these strategies must be applied within the proper context of culture and language, for example. Because psychology is becoming more international and counseling is being interpreted differently in other countries, understanding other counseling approaches will assist counselors in the United States in becoming a part of the global network. It is also noteworthy that colleagues in other fields are approaching the lack of multicultural competency in similar ways that will be valuable to counseling psychologists (Pedersen & Leong, 1997), VR counselors, and other mental health professionals serving people with disabilities in the United States. Because our human service organizations (e.g., VR agencies) are viewed as a microcosm of the larger society in which we reside (Wilson, 2000; Wilson et al., 1999), possible intolerance and prejudice within these institutions must be addressed.

Racism and Multicultural Competency

No other issue solicits such strong emotion as racism in our educational and political systems. However, as racism and intolerance relates to multicultural competencies, Locke and Kiselica (1999) suggested that discourse on racial matters must be implemented, and it must begin with an understanding of what racism is and what it does to human beings. Locke and Kiselica further adduced that:

> Racism hurts people of color and Whites alike. It creates barriers among peoples and prevents them from making substantive contact with each other, from discovering and enjoying the beauty that each group has to offer. It keeps people of different colors at a distance from each other, locked within their own fears and misconceptions.... But gently and lovingly challenging people to address these fears can help them move beyond their pain and fears, examine their erroneous beliefs about one another, and consider possibilities, such as cross-cultural boundaries, that were previously denied to them. (pp. 80-81)

With educators' modeling being an important component in teaching about racism and intolerance, it is imperative that we focus on race and racism in multicultural counseling courses. "Sharing one's personal struggles with issues surrounding race and racism will helps students see that faculty members are continually learning, progressing, and sometimes, failing" (Locke & Kiselica, 1999, p. 82). Teaching about racism in a multicultural counseling course is a challenge facing most educators in the United States. Locke and Kiselica also reported that creative teaching strategies, rather than the traditional lectures, can also help the instructional process become less threatening and more productive for most individuals. The authors believe that educators must continue their efforts in addressing multicultural issues in ways that will facilitate understanding of other races and ethnicities in and outside of the classroom. Because appropriate or healthy modeling gives the impression that teachers are still learning about prejudice, modeling is a vital strategy in teaching students and others to address racism and other kinds of isms.

Collaboration with People of Color

Collaborating with people of color is not only a way to increase the potential magnitude of multicultural research and classroom activities, but also a way to gain empathy for people who look different than White Americans. Supporting the collaboration idea, Ponterotto (1998) theorized that multicultural research should be guided by the often-ignored voices of scholars of color. It is also important that White American researchers approach and collaborate with racial and ethnic minority scholars and students in their research and training efforts to enhance multicultural research in each area of the human services. In addition, research needs to address the impact of having multicultural classes that are culturally balanced in both students and faculty members. Research is also needed to find training environments and activities most conducive to raising levels of racial/ethnic identity development, if future research supports the relationship between higher levels of racial/ethnic development and multicultural competency. Furthermore, there is also a need for all counseling programs to have multicultural mentors to guide, support, and serve as role models in this collaboration endeavor (Ponterotto, 1998). Atikinson, Thompson, and Grant (1993) proposed the use of out-of-office sites and activities (clients' homes, churches, work environments) and alternative helping roles (consultant, advocate, facilitator) as aids for improving multicultural competency. For counselors to be culturally skilled, they must become actively involved with racial and ethnic minority individuals outside the counseling setting so the perspective of their minority students and clients is more than just an academic experience (Sue, 1996). Recently, Arredondo (1999) suggested that therapists need to learn more about intervention instruments and strategies, but always with an understanding of their cultural-bound limitations. The multicultural counseling competencies proposed by Sue et al.

(1992) provide developmental and evaluative guidelines for improving multicultural counselors within higher education. The authors see this developmental process referred to by Sue et al., as a start in the right direction. Finally, the quote by Pope-Davis and Ottavai (1994) is obviously relevant as we enter the next century:

> As we move toward the 21st century, we anticipate that the ethnic diversity of our society will increase. Given this reality, unless counselors practicing in the field, or those in training, increase their multicultural competencies, they will have little opportunity to have a positive impact on the needs of an emerging diverse society. (p. 654)

Specific Tools/Strategies to Assist With Racial and Ethnic Minority Clients

Although the below model communicated by Parham (2002) was meant for African American clients, we think the model could be used for other racial and ethnic diverse clients during the counseling process. Please refer to Parham for further information on the below model/tools.

1. Connecting with your clients: Because there are several ways to connect with clients, counselors may want to consider creating an atmosphere that would facilitate the client being open during the therapy process, and being present with the client during the therapy process.
2. Assessment: As Parham (2002) noted, there are several techniques that contribute to a therapist's ability to assess what is going on with the client. Understanding cultural strengths and using appropriate clinical instruments are only two tools to consider.
3. Facilitating Awareness: Rephrasing, understanding functional behaviors, and assisting clients to understand their language and values are but three ways to facilitate client awareness during therapy.
4. Setting Goals: As Parham (2002) noted, the goals that you have in therapy will chart the course of healing. It is important to respect the need for client distance and examine the client from a culturally centered theoretical assumption.
5. Taking Action and Instigating Change: Empowering, teaching, and becoming a social advocate and engineer on behalf of the client, can assist the client to confront and handle their circumstances in a productive way.

Future Direction

"Scholarly research on culture and on counseling clients of differing cultural backgrounds appearing in counseling and psychology publications reflects the steadily rising professional status of multicultural counseling" (Baruth& Manning, p. 18, 2003). "Yet, the paradox of our position as professional psychologists, psychiatrists, social workers, and counselors is that although we have amassed a number of classes and applied counseling hours, in many ways we are less prepared to provide services to certain populations" (Parham, p. 1, 2002). Although multicultural counseling as an area of specialization has been around for approximately 35 years (D'Andrea & Daniels, 1996), counseling and psychotherapy still tends to overlook clients who differ from the majority culture (Baruth & Manning, 2003). In reviewing the literature, there have been two trends that would assist counselors with being effective in treating people who are racially and ethically diverse (Casas & Vasquez, 1989): (1) attempt to identify what particular approaches and theories facilitate multicultural counseling, and (2) modification of perspectives from which the area of multicultural counseling may view the individual (e.g., ethnic identity) and the counseling and/or societal milieu (e.g., race and assimilation). Patterson (1996) suggests that future research should also be directed at studying developmental issues of various racial and ethnic groups throughout the lifespan. Finally, Draguns (1989) suggests that research should focus on multicultural counseling with either the etic (e.g., focus on both similarities and differences of groups being examined) or emic (examining a given culture without comparing to other cultures) approaches.

Because counselors tend to consider the client's individuality, many times the counselor was not trained to consider the cultural background of the clients they served (Draguns, 1989). In fact, Draguns reports that the current emphasis on multicultural counseling illustrates that counselors are not recognizing that diverse clients may be from differing cultural backgrounds. It is important that counselors (1) are open to expanding their multicultural competencies; (2) gain needed exposure to groups that are culturally and/or racially different than the majority culture; (3) continue seeking continuing education when necessary, and (4) display behaviors that facilitate trust and rapport building during the therapeutic process.

Conclusion

"Multicultural counseling programs are noticeably deficient in relating race and culture-specific incidents and counseling skills that the culturally competent counselor must possess" (Sue & Sue, 1990 p. 14). According to Pope-Davis & Ottavi (1994), students and practitioners need training in multicultural counseling that is not only effective, but also integrative and organized. For example, though instructional media presently has a role in training, other modes are also needed to increase exposure to populations who are different from ourselves. There are several limitations in multicultural training models, one being the assumption that acquiring appropriate knowledge and skills is sufficient to be a culturally skilled counselor (Sue & Sue, 1990). Nonetheless, the question remains how do we actually acquire multicultural competencies that will truly benefit the clientele we serve?

In their document concerning counselor competency and the assessment thereof, Sue et al. (1992) reminded us that there has been a long history of recommendations regarding the need for integrating multiculturalism in the counseling profession as well as developing multicultural competencies. Numerous conferences held by the American Association for Counseling and Development (AACD) now the American Counseling Association (ACA), the American Psychological Association (APA), and other government sponsored events have noted the serious lack and inadequacy of training programs for dealing with racial, ethnic, and cultural matters. Since the 1970s, there has been an increase in both literature and graduate programs addressing the need to develop multicultural awareness (Sue et al., 1992). Although there has been great gains within the multicultural community to increase competencies among human service professionals, there is however, fear among some multicultural specialists that some individual programs (a) view multicultural courses as less legitimate than other counseling requirements, (b) are taught primarily by junior-level faculty, (c) are haphazard and fragmented without a strong conceptual framework linked to specific competencies, and (d) tend to deal with cultural differences from an intellectual perspective without considering the sociopolitical ramifications of counseling (Sue & Sue, 1990). If one views the classroom as a microcosm of society, then the statement by Sue and Sue in 1990 may still hold true. "In reality, most counselors do not have enough practical experience in training, nor in their daily lives, with racial and ethnic minorities" (Sue et al., 1992, p. 477). Sue and Sue stressed that cross-cultural competence is a never-ending process. Implicit in this notion is recognition of the complexity and diversity of client populations and acknowledgement of our own personal limitations. Moreover, there will always be room for improvement. Throughout the literature reviewed, all researchers agree on one main theme; that better and more varied methods are needed for developing and assessing competency in the field of multicultural counseling. The authors suggest that counselors in general, are not primed for the next Millennium. As this debate continues, only time will judge the accurateness of this supposition.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 *Winter 2003*

Countertransference and the Hidden Client in Counselor Training and Supervision

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Countertransference is a common construct in counselor training and supervision. Recent trends in the counseling profession reflect an expanded conceptualization of countertransference that includes all counselor emotional reactivity as countertransference. The emotional experience of working with clients and the complexity of the counseling relationship justify the development of a multidimensional countertransference supervision model. Based on these recent trends and observations as a counselor supervisor, I have proposed a supervision model that acknowledges countertransference when it occurs within the following categories: (a) when the counselor experiences reactivity to client characteristics, issues, or situations that awaken unresolved feelings within the counselor, (b) when the counselor experiences reactivity to self-expectations in regard to client progress, (c) when the counselor experiences reactivity to the organization that impacts the counselor-client relationship, and (d) when the counselor experiences reactivity to supervision that impacts the counselor-client relationship

Theodore Reik, author of "Listening With the Third Ear" (1948) identified the "hidden client" in psychoanalysis and stated, "in beginning to comprehend another we discover a clue to ourselves" (p. 433). Although this notion of the hidden client within the counselor is obscure, it retains relevancy for contemporary counseling practices. The hidden client refers to those aspects of the counselor that are outside awareness and become awakened within the counseling session.

A core practice of supervision is the identification of such countertransference and its implications within the therapeutic relationship. The supervision process for counselors, then, provides an arena for this type of reflective inquiry (Neufeldt, 1999), and self-awareness and self-reflection promote an understanding of the hidden client. Recent practitioners have expanded the conceptualization of countertransference to include broader areas of counselor awareness. This broader conceptualization of countertransference is needed as counselor trainees encounter the living experience of clients, which typically produces significant amounts of counselor reactivity. Because counselor reactivity is heightened during the internship supervisory experience, supervisors must systematically address counselor countertransference during this training period.

Overview

Transference and countertransference are core constructs in the training of therapists and counselors. The traditional psychoanalytic definition of transference refers to the clients' manifestation of "unconscious, unresolved, and conflicted patterns of interpersonal relationships in the therapeutic setting" (Hill & Williams, 2000, p. 685). Transference typically represents unresolved early childhood issues and reflects patterns of present relationship problems. Transference reactions reflect distortions since the client places characteristics onto the therapist that belong to others. Psychoanalysts Frawley-O'Dea and Sarnat (2001) state that "transference manifestations are assumed to be intrapsychically motivated and wholly constructed by the patient; and the analyst is a neutral recipient of the patients' fantasies and projections" (p. 15). Analysis and interpretation of transference attempts to provide the client with insight into unresolved issues and relationship difficulties.

Conversely, countertransference refers to the therapists' reactions to the client "that originate in unresolved issues in the helper" (Hill & O'Brian, 1999, p. 181). The classical Freudian definition refers to the distorted reaction of the analyst to the client's transference (Hill & Williams, 2000). More recent viewpoints include all of the therapist's reactions to clients as countertransference. Hayes, Riker and Ingram (1997) studied triggers and manifestations of therapists' countertransference. They contend that culture issues, such as race, ethnicity, gender, and sexual orientation may result in an unexplained bias that also determines countertransference reactions. Counselor countertransference is a complex phenomenon. Outside of the counselor's awareness countertransference can interfere with the therapeutic alliance and treatment outcomes. Within awareness, countertransference can become an essential therapeutic tool (Gelso & Carter, 1984; McClure & Hodge, 1987; Watkins, 1985; Cormier & Hackney, 1999).

Cormier and Hackney (1987) contend that relationship building is critical to counseling process and that transference and countertransference may interfere with this process. They deem it essential for the counselor "to recognize psychological dynamics, interpersonal assumptions, and the subterranean emotions that are part of the relationship" (p. 26). Gladding (2000) describes countertransference "as the counselor's projected emotional reaction to or behavior to a client, and contends that these reactions can destroy the counselor's ability to be therapeutic, let alone objective" (p. 158). Counselors are implored to work through negative and counterproductive countertransference.

Brems (2001) offers a definition of countertransference that differs from the unidirectional traditional psychoanalytic definition. She summarizes that the here and now relationship between client and clinician is always affected by both the client's transference and the therapist's countertransference. Brems (2001) and Teyber (1997) recommend here and now processing to facilitate insight into client needs and motivation for change. Brems contends that countertransference is often a result of a lack of self-awareness on the part of the counselor. Her approach on countertransference includes suggestions for increasing counselor self-awareness.

Group work theorist Irving Yalom (1995) writes about here and now group process and transference. Yalom refers to transference as interpersonal perceptual distortion: "although the therapist is the personification of parental images, of teachers, of authority, of established tradition, of incorporated values, patients are also conflicted in other interpersonal domains: power, assertiveness, anger, competitiveness with peers, intimacy, sexuality, generosity, greed, envy" (p. 44). Yalom recommends that patients work on insight surrounding their issues, ideally through the interactions with other group members, and that leaders understand the prevalence of transference as well as their own countertransference responses.

Bemak and Epp (2001) discuss the complexity of countertransference for graduate student group counselors. Their premise is that even though countertransference is widely recognized, "it continues to be an elusive issue in counseling that has not been addressed systematically" (p. 307). Their model appears to be an effective teaching method that offers an expanded view of countertransference in group work:

> Rather than reactions to only one client, the group counselor is now in a position of simultaneously responding to five different levels, which are as follows: (a) individual clients within the group; (b) client interactions with each other in the group; (c) client interactions with you, the group counselor; (d) the group as a whole entity; and (e) one's own personal issues and responses that emerge as a result of an interaction of the other four levels. (p. 306-307)

Students who operate as group leaders are taught to be externally observant of group members and simultaneously mindful of their own inner reactions. Supervisors are to establish explicit norms that encourage graduate students to openly and positively discuss countertransference and their personal reactions and feelings as group leaders. It is evident that this model provides systematic attention to countertransference in the training of group counselors.

In summary, this current review of the literature has yielded both classical definitions of transference and countertransference as well as an expanded conceptualization of countertransference. Bemak and Epp (2001) described an expanded multidimensional model of countertransference for graduate group counselors. They recognize the complexity of the group situation and the potential for transference and countertransference. Their model generates systematic attention to countertransference in group counselors-in-training.

Multidimensional Training Model

Countertransference is a core construct in counselor training within both individual and group counseling. Most of the literature draws reference to countertransference but does not offer a training model for emerging professional counselors, particularly regarding individual counseling. As director and supervisor of the practicum/internship experience within a graduate Community Counseling program, I have become increasingly aware of countertransference issues. I am grateful to recent groups of students who have been openly willing to identify and discuss countertransference. Student levels of self-knowledge are impressive. Counselor trainees are certainly inquisitive and the coursework curriculum infuses opportunities for active learning and intraception (i.e. helping relationships, group dynamics, family systems, human development). It is through these collaborative efforts and being cognizant of the larger purpose of counselor training, along with the impetus provided in the literature (Bemak & Epp, 2001; Brems, 2001), that I have begun to develop a multidimensional approach to addressing countertransference.

Counseling programs, as a whole, require a rather expansive practicum and internship experience designed to do the following: provide an opportunity to connect learning; stimulate a theoretical orientation; formulate a worldview as a helper; and develop career goals. Furthermore, internship is ideally designed to promote "self-understanding, self-discipline, and self-confidence" (Sweitzer & King, 1999). Students typically attain field site placements in organizations that provide direct service to socially vulnerable clients. Others may provide direct services to involuntary groups of adjudicated delinquents, or adult offenders. In their book, *The Successful Internship*, Sweitzer and King (1999) discuss how internship is a human experience, and that "direct work with clients generates psychological, intellectual, and emotional energy" (p. 131). Internship students begin experiencing real situations and are often touched if not overwhelmed by the living situations of their clients.

Consequently, supervision is necessary for helping students examine emotional reactivity in order to meet the real life challenges of clients. The multidimensional conceptualization of countertransference presented in this paper has evolved partly from my work with students in this capacity. Through this work, I have observed and delineated several common and reoccurring themes that constitute this expanded conceptualization of countertransference. This conceptualization is not intended to be inclusive, nor are the categories definitive. They are presented to provide a framework for assisting supervision and for stimulating further investigation. This broader definition of countertransference encompasses all counselor emotional reactivity when it occurs within the following categories: (a) when the counselor experiences reactivity to client characteristics, issues, or situations that awaken unresolved feelings within the counselor, (b) when the counselor experiences reactivity to self-expectations in regard to client progress, (c) when the counselor experiences reactivity to the organization that impacts the counselor-client relationship, and (d) when the counselor experiences reactivity to supervision that impacts the counselor-client relationship.

Counselor Reactivity to Client Variables

The counseling relationship offers the opportunity for authentic interpersonal interaction between the counselor and the client. Client characteristics, issues, or situations may emerge that evoke emotional reactivity, and awaken unresolved issues within the counselor. Theodore Reik (1948) identified the "hidden client" in psychoanalysis and stated, "In beginning to comprehend another, we discover a clue to ourselves," (p. 433). Reik referred to the revealing of the hidden client within the counselor as the "reciprocal illumination of unconscious happenings." The hidden client represents the preconscious aspects or repressed issues of the counselor that emerge when they are awakened within the counseling session. Counselors who are unaware of their motivation may react towards or away from the client in a tropistic manner. Others have referred to this phenomenon as projective identification and recommend that supervisors help counselors understand their motivation in regard to "life history and work with clients" (Ivey, D'Audrea, Ivey, & Simek-Morgan, 2002, p. 148). Counselors trainees may not always be aware of the implications of their unresolved conflicts. They may also be unaware of personal biases and values that impede upon the counseling relationship.

This category reflects classic countertransference. The counselor projects onto the client an emotional or distorted viewpoint. Family of origin issues and other unresolved interpersonal conflicts are implicated here. It is easy to comprehend that if someone reminds us of another person, we may react accordingly. Preconscious behavior patterns ensue. For the counselor this may be less than therapeutic and may manifest itself through polarized attraction or conflict. This can interfere with accurate psychological interpretation and development of the therapeutic alliance. Ultimately such countertransference impedes the effectiveness and progress of therapy.

Counselor biases and values are not always manifested as projected distortions outside of awareness. Instead counselors are sometimes acutely aware of their emotional reactivity. However, they may not always be cognizant of the impact on therapeutic interactions. Certain clients may display traits or behaviors antagonistic to the humanistic, religious, gender, or racial beliefs of the counselor. Conflicted feelings may result in disidentification or moving away from the client. Supervisees quickly discover their levels of tolerance and may experience dissonance over their conflicted feelings. All of these events and emotions awaken the hidden client and become reflective events processed in supervision.

The antidote for countertransference is counselor self-awareness. Neufeldt (1999) reviewed supervisory practices for the first practicum and stated that counselor development occurs as a result of continuous personal reflection. Supervisors were recommended to establish an atmosphere that promotes active reflection and reflective inquiry. "The process involves attention to the therapist's own actions, emotions, and thoughts in the counseling session, and to the interaction between the client and the therapists" (Neufeldt, 1999, p. 6). Cormier and Hackney (1999) claim that "the skillful counselor develops a self-congruent style for meeting clients, a style that reflects both the counselor's personal qualities and counseling experiences" (p. 20). A reflective and developmental practicum experience helps the supervisee attain this self-congruent style.

The human living experience of field placement can evoke strong emotions that impact the counseling relationship. I frequently use the term healthy detachment to discuss appropriate emotional boundaries and separation. Although students are not entirely idealistic, they do believe in and display a self-deterministic lifestyle. Initial encounters with clients less fortunate and immersed in fatalistic life situations can be unsettling. The following examples illuminate these issues.

An empathetic counselor trainee, who is also a family oriented mother, reported shock and disbelief at the horrendous story told by a troubled and pregnant teenager. Initially she felt shock and sadness, but later reported feeling exhausted, depleted, amazed, depressed, and angry. She also found herself crying on the way home from the treatment facility. She processed these emotions by speaking with a more experienced counselor that she respected and, concluded the following: "You have to realize that by fully losing yourself in the world of the client, you are not helping. You need to realize that this client is looking for your help, and you must stay focused and ready to give them this help. If you jump into their horrific world, you will not alleviate their pain; rather you will create your own." The ability to process emotional reactions has allowed this student counselor to integrate this learning experience.

Counselors, like the one above, such as these are usually surprised when their countertransference is brought into full awareness. Countertransference occurs when the counselor's past or present situations are similar to the client's present situation. Thus, the counselor becomes overidentified and perhaps over-involved. A former student reiterated that she was especially challenged in practicum when the supervisor presented that she wanted to rescue or mother a lonely female adolescent client. She shared a journal written later that night that examined her own issues regarding abandonment and rejection. That student recorded many rich metaphors regarding the need "to keep boundaries in place around my heart and mind to keep the focus aimed outward, not inward....". She found that "countertransference can be so subtle in that we may feel that if we just took on their problems, then we could make them all better." This counselor trainee now finds herself being rather effective with this particular group of adolescents and writes that "countertransference can be quite powerful in session; it can help us connect with what is going on with a client; it is empathy to the n'th degree and can be a tool for therapy." These examples convey heart-felt and powerful learning experiences as a result of self-reflection and self-understanding.

Counselor Reactivity Regarding Client Progress

In the former category, countertransference occurred when the counselor responded to a client characteristic or specific situation. In this category, countertransference is merely a reflection of the counselor's intrinsic presentation. For instance, countertransference is activated when the counselor's needs or expectations of self are not realized in regard to client progress. In the early stage of supervision, beginning counselors typically desire to present descriptive histories and psychological impressions about their clients. Supervisors usually redirect the focus of interpretation to the interaction and quality of the therapeutic relationship. Supervisees quickly realize that supervision is really about themselves and not client issues. "This process involves attention to the actions, emotions, and thoughts of the therapist in the counseling session" (Neufeldt, 1999, p. 6). Kell and Mueller (1966) relate that supervision helps the counselor to "differentiate their own feelings and conflicts from those of the client" (p. 103). This differentiating, in turn, helps facilitate the counseling relationship.

Teaching moments in supervision occur when the counselor experiences a barrier and is unsure how to proceed. Client defenses may activate to resist change or deter the counseling relationship, and a reciprocal event occurs when the counselor's anxiety and defensiveness emerge. Kell & Mueller (1966) refer to this as a therapeutic impasse. Regarding this impasse, the counselor confers with the supervisor for expert advice, who in turn, illuminates the parallel process and escorts the supervisee to examine his or her own anxiety and defensiveness concerning the impasse. This self-reflection allows the counselor to analyze feelings of adequacy, conflicted emotions, and responses to the client. Frawley-O'Dea and Sarnat (2001) offer a theoretical review of parallel process: "the supervisee conveys their dilemma upward and the supervisor helps them with conscious awareness, elaboration, meaning making, and discussion of what has not yet been verbally expressed" (p. 182). Parallel process tends to be an activating and enlightening event.

Parallel process and a reciprocal counselor-client process imply that the therapeutic relationship is enhanced when counselors become aware of the meaning of their own behaviors. Unaware counselors frequently find themselves at the therapeutic impasse. This point is emphasized by Albert Ellis's article (1983), "How to Deal With Your Most Difficult Client – Yourself." Ellis expounded on how counselors block their own effectiveness. In my discussions with trainees about "our most difficult client," these trainees typically refer to issues of competency. Competency is a common concern among beginning interns (Sweitzer & King, 1999). Kell and Mueller make a stronger statement: "Counseling is, after all, just the professional embodiment of the counselor's personal needs to achieve, to be recognized, and deemed an adequate person" (1966, p. 108). Although a rather strong statement, I concur that graduate students and most professional counselors are inherently achievement oriented. Undoubtedly, the need to achieve is rewarded with academic success. Yet, this need typically interferes with the tasks of therapy. The enthusiasm and eagerness that comes out of the need to achieve brings impatience. Several former supervisees have empathically exclaimed: "I get so upset when my clients don't let me do what I need to do to help them." Hence, successful treatment outcomes become a contingency for counselor self-worth. Resultant frustration occurs when desired outcomes are not attained.

The intrinsic needs and values of the counselor may also become self evident when they encounter the perplexity of the therapeutic impasse. When met with an impasse the achievement orientated counselor typically seeks out more information on clinical intervention. The intrinsically nurturing counselor, at impasse, tends to exert more effort to connect with the client. The first counselor, in the quest for efficiency, may glance over emotional laden process. The second, empathetic counselor, may falter in case conceptualization and clinical interpretation. In addition, controlling, impatient counselors may resort to excessive persuasion or advice giving. Ridged, dogmatic counselors tend to be judgmental or "professionally myopic" (Sweitzer & King, 1999). Competitive individuals may not disclose any dissonance over their performance and may blame poor outcomes on clients, supervisors, or the work setting. Although these examples are generalizations, they emphasize how idiosyncratic and intrinsic counselor values can manifest themselves in the counseling and supervisory setting. The stronger the counselor's trait that lies in unawareness, the more likely it is to interfere with therapeutic effectiveness. Fortunately, once trainees encounter and acknowledge their most difficult client, themselves, they are often able to ameliorate and modify their behaviors regarding these traits within the counseling relationship.

Counselor Reactivity to the Organization

This category examines counselor reactivity pertaining to the organization. Such countertransference occurs when the counselor's reactivity to the organization impacts the counselor-client relationship. Initially, the role of the counselor trainee is precarious; they quickly need to seek out and establish roles with supervisors, colleagues, peers, and clients. Being mindful and respectful of the organizational culture helps students to better negotiate these roles. Supervisors can increase students' knowledge of organizations with a review of systems theory that includes a formal assessment of the mission statement, structure, and service delivery. Also, supervisors can help students verbalize their informal impressions of the atmosphere and climate of the work environment.

Students embrace the field site learning experience with enthusiasm and positive expectancy. Ideally, most students find a good fit and retain a positive outlook. However, some students soon discover that a discrepancy exists in most organizations between the formal organizational goals and the informal operational goals. This discrepancy often produces disconcerting dissonance in these active learners. Sweitzer and King (1999) refer to this as the disillusionment stage of internship:

> You might find yourself frustrated by what you consider the coldness and slowness of the system, the reduction of people to inhuman status, and the realities

> of dealing with bureaucracies, as well as under funded and under staffed community programs. (p. 139)

Disenchantment occurs when the particular worksite does not fulfill students' needs and expectations. Social psychologist Janoff-Bulman (1992) contends that the core of the human assumptive world is comprised of fundamental beliefs in a world that is benevolent, meaningful, and the self as worthy. I believe that people project and maintain similar assumptions on to organizations, to be fair, just, responsive, and perhaps efficient. Disappointment over lost assumptions results in disillusionment and ill feelings. This disillusionment can become a critical career development event. How students learn to work through this phase may impact future work-style and job satisfaction.

Emotional reactivity to the organization has the potential to adversely impact the counselor-client relationship. Counselors should be mindful of how they react to the organizational setting. For example, I became alarmed when a counselor trainee became triangulated between the client and the agency. This trainee colluded with the client, that the residential treatment facility was harsh and unfair. Consequently, the counselor role and objectivity was compromised when the trainee began to advocate for the client against the agency. Issues of authority and distrust were processed in order to avert a potentially hazardous role for the trainee. Another instance occurred when a trainee revealed that her residential client held an antagonistic view of the clinical supervisor. Although she secretly concurred with the expressed opinion of her client, she did not reveal this throughout the counseling session. She deemed it would be anti-therapeutic. This trainee struggled with being authentic, but was more concerned with how these shared but unexpressed feelings would impact treatment effectiveness. As evidenced, counselor reactivity to the organization warrants categorization in this expanded conceptualization of countertransference. At present, however, organizational influence on the counselor-client relationship is under addressed in supervision. Until now, countertransference work has primarily centered on counselor self-discovery. Future inquiry into this area may also advance the conceptual understanding of counselor work stress, job satisfaction, and self-preservation.

Counselor Reactivity to Supervision

The previous categories revealed that countertransference frequently becomes illuminated within the supervisory session. Ideally, the supervisor will establish an atmosphere of reflective inquiry that promotes a productive and developmentally safe setting. However, there may be times when the counselor experiences countertransference in reaction to supervision. The resultant counselor role conflict warrants categorization in this multidimensional model.

The literature on supervision is well referenced and researched. A comprehensive overview of psychotherapy supervision has been compiled by Watkins (1997). This edited review reveals the numerous theoretical approaches, components, contextual factors, and complexities of supervision. This literature is indeed valuable to the practice of supervision; however, only narrow portions pertain to an expanded conceptualization of countertransference. In particular, Dewald (1997) contends that a learning alliance will evolve if a comfortable and safe situation is established. This assures that the learning needs of the supervisee are accommodated. Dewald stated the following:

> The supervisee discovers that the supervisor can recognize and accept some of the issues and conflicts in the supervisee's experience; and that the supervisor

> will offer predominately constructive feedback, ... even if at times it may involve pointing out difficult or painful limitations or errors. (p. 37)

The learning alliance and supervisory relationship can be impacted when the counselor is influenced by certain contextual supervisor factors: age, gender, culture, experience, and theoretical orientation (Holloway, 1997). The context in which supervision occurs is also reported to evoke anxiety (Neufeldt, 1997). If a learning alliance does not evolve, then a conflict-dominated situation emerges in which the supervisor and counselor become overly impressed with the evaluative aspect of supervision.

Other authors have acknowledged that the evaluative nature of supervision produces anxiety (Cormier & Hackney, 1999.) This anxiety is considered an inherent and expected aspect of supervision. Undoubtedly, undue or unaddressed anxiety could detract from the learning alliance. Heightened anxiety can make a counselor insecure or uncertain about their role in supervision as well as in counseling. Olk and Friedlander (1992) have referred to role conflict and role ambiguity that resides within the counselor in regard to supervision. When this occurs, supervision becomes a threatening situation. Liddle, (1986) examined counselor resistance to supervision as a response to the listed perceived threats: evaluation anxiety; performance anxiety; personal issues within the supervisee; deficits in the supervisory relationship; and anticipated consequences. All of these writers infer that these fears need to be uncovered and processed in a productive manner within the supervisory setting.

Excessive anxiety prompts a conflicted learning situation that often interferes with the counselor's integration of learning, as well as the supervisor's perception of their progress. Accurate assessment of counselor limitations requires the supervisor to discriminate between anxiety about learning as opposed to anxiety about evaluation. Dewald (1997) cites differences between "limitations on errors based on lack of experience and conceptual ignorance and those based on the student's attitude, personal or transference issues, or significant learning inhibitions or blocks" (p. 36).

The above literature describes how counselors present in supervision. Countertransference, then, subsequently occurs when the counselor reactivity to supervision impacts the counselor-client relationship. In an effort to avoid in-depth scrutiny the counselor may engage only in surface issues with the client. An unconscious collusion can occur in which the counselor does not challenge the client and the client does not provoke the counselor's anxieties about being a counselor. In essence both maintain a safe level. Being uncomfortable with supervision and experiencing anxiety about evaluation can adversely affect the counselor's responses during counseling sessions. This kind of counselor reactivity to supervision is important for supervisors to identify and process with trainees. By delineating and providing systematic attention to these countertransference responses, the supervisor enhances the evolution of a more productive supervision learning alliance and counselor-client relationship. As evidenced, the multidimensional model of countertransference encompasses the counselor who experiences reactivity to supervision.

Discussion

Countertransference work has been a central construct in counselor training and supervision. Fundamental to countertransference work is an atmosphere of acceptance and self-reflection. This practice of addressing countertransference helps to develop a counseling professional prone to self-awareness, self-reflection, and self-development. The recent trend towards expanding the concept of countertransference has provided the impetus for developing this multidimensional supervision model, which systematically addresses countertransference through the following categories: (a) when the counselor experiences reactivity to client characteristics, issues, or situations that awaken unresolved feelings within the counselor, (b) when the counselor experiences reactivity to self-expectations in regard to client progress, (c) when the counselor experiences reactivity to the organization that impacts the counselor-client relationship, and (d) when the counselor experiences reactivity to supervision that impacts the counselor-client relationship.

The criteria and examples delineated in each of the categories of this multidimensional model are not inclusive. These categories are merely a tentative framework from which to provide possible direction for supervision and for future inquiry. Further investigation may be beneficial in the following areas: prevalence of countertransference, supervisory practices for increasing counselor self-awareness, the relationship between countertransference and compassion fatigue (Figley, 2002), and counselor reactivity to both organizational and supervisory experiences.

Reiterated throughout this paper is the contention that counselor preparation can benefit from systematic attention to countertransference work. Countertransference work contributes significantly to counselor development and to the quality of counselors' many present and future counseling relationships. Also an expanded conceptualization of countertransference, such as the one presented here, encourages the counselor professional to maintain systematic awareness of this commonly occurring phenomenon.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 *Winter 2003*

Emerging Trends in College Counseling Centers

Abstract

John Patrick and Kelly Tuning

Seven emerging trends that will affect college counseling centers in Pennsylvania were investigated. These include: (1) providing services to students who present with more severe mental health problems than in the past; (2) counseling within a changing campus climate that is marked with concerns of substance abuse, intolerance, and violence; (3) counseling an increasingly diverse student population; (4) increasing use of brief counseling and therapy as the preferred mode of individual service delivery; (5) expanding use of interactional and Internet-based technologies for counseling services delivery; (6) responding to limited resources and increased demand for accountability; and (7) outsourcing counseling services and/or utilizing managed mental health care on campus (Humphrey, Kitchens, & Patrick, 2000; Cooper & Archer, 1999; Levine & Cureton, 1998; Sharkin, 1997).

O'Conner (2001) summarized data from the National Survey of Counseling Center Directors that showed 84 percent of center directors noticed an increase in severe psychological problems, learning disabilities, substance abuse, and/or sexual abuse issues. Questions related to the ability of counseling centers to serve as mental health outpatient facilities have been raised. To what degree should a college counseling center be providing mental health and substance abuse counseling and does the institutional mission justify these services? Do college counselors have the necessary competencies to work with complex clinical problems such as mood disorders, eating disorders, and substance abuse? Should college counseling centers be involved with medication management? When will psychiatric consultations occur? Will college counseling centers be able to engage in long term psychotherapy with students? If not, what is the referral process? Is there available funding and resources to provide adequate counseling services? Accurate assessment, differential diagnosis, resource/referral identification, and diverse intervention options are critical when working with students presenting severe psychological problems (Humphrey, et al., 2000).

Almost every college campus in Pennsylvania will experience events involving substance abuse, violence and/or intolerance. How will college counseling centers balance the competing needs for prevention and the delivery of direct client services? What role will administrators ask college counselors to play in discipline proceedings and the campus judicial system?

Humphrey and colleagues (2000) noted that gender, age, sexual orientation, culture, religious identification, disability/ability, economic status, race, ethnicity, and language differences have had a dramatic impact on college life, academic achievement, and student problems. Levine and Cureton (1998) concluded that these student characteristics increase tension on college campuses by allowing for: (1) an emerging sense of victimization with a concomitant clamor for redress; (2) a preoccupation on highlighting differences without acknowledging commonality; (3) homogenous student groups that

exclude more than they include; and (4) informal campus segregation through the use of territorial designations (e.g., where a student is allowed to seat or eat in campus facilities). Humphrey and associates (2000) also emphasized that campus diversity challenges traditional practices of counselors trained with male-oriented, Eurocentric counseling theories and models. These theories and practices often prove inadequate when applied to a diverse and changing student population and may promote cultural bias. It is essential for college counselors to consider the limitations of their professional training as well as the cultural bias inherent in some clinical practices.

Cooper and Archer (1999) highlighted brief counseling modalities as the preferred mode of individual service delivery at college counseling centers. Brief counseling is effective with a wide range of clients and problems, including the types of developmental, crisis, and situational problems often presented by college students. Brief counseling also fits for those students who expect a practical and active way to confront a problem or difficulty. Steenbarger (1993) identified two sources of resistance to the use of brief therapy in college counseling centers. Professional autonomy is reduced and improvements made through abbreviated treatment are less significant than those from long-term interventions (Steenbarger, 1993). To support success with brief therapy in college settings, Pinkerton (1996) encouraged counselors in college counseling centers to embrace the following attitudes and skills: (1) belief in the effectiveness of brief therapy, (2) comfort with a position of authority; (3) comfort with modest goals, (4) ability to make a rapid and accurate assessment, and (5) the ability to establish a positive relationship rapidly.

College counselors will increasingly use a wide variety of interactional and Internet-based technologies for counseling services delivery, outreach programming, advertising, resource management, and professional training. Already college counseling centers are using Email, bulletin boards, chat rooms, listservs, World Wide Web-based homepages, and simultaneous audio and video transmissions. There is a need to modify traditional counseling methods and techniques to fit effectively with simultaneous audio and video transmissions, maintain ethical practice, and to ensure transmission security. Acquisition of adequate skills in using interactional technologies as well as making certain that the technology is user-friendly for student clients are also necessary considerations (Humphrey et al., 2000; Sampson, Kolodinsky, & Greeno, 1997).

One of the realities facing Pennsylvania college counseling centers is the increased demand for accountability and evaluation of student services coming from a variety of sources including government officials, boards of trustees, parents, administrators, faculty, and students. As a consequence of the recent economic downturn in Pennsylvania, college counseling centers will continue to face cuts in budget and staff. College counselors are faced with the reality that they must take on additional roles, which may in turn reduce time available for counseling. They will also be expected to prove their viability within the institution and various outside constituent groups. If college counseling centers are to "weather the storm" and demonstrate their productivity and effectiveness, then college counselors must establish accountability and evaluation procedures that gather, analyze, and report data by criteria other than student satisfaction, preferably using measures of retention, graduation rates, usage rates, and student involvement in college counseling programs (Patrick & Niles, 1988).

Phillips, Halstead, and Carpenter (1996) noted the emerging trend of privatizing or outsourcing college counseling services. Humphrey and colleagues (2000) emphasized that the decision to keep college counseling programs will hinge on the perceived costs of outsourcing and the demonstrated benefits accrued by having college counselors attenuated to the needs of the campus community.

Recommendations for college counselors include developing counseling services germane to substance abuse and violence; seeking continuing education; maintaining a developmental orientation supplemented with clinical information; involvement in research on the nature and extent of college problems; being proactive in responding to accountability and limited resources; resisting cultural encapsulation; creatively using technology for effective counseling service delivery; and considering employing brief therapeutic approaches in college counseling (Humphrey, et al., 2000).

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Multiple Intelligences Approach to Conflict Resolution

Abstract

Nadine E. Garner

The Skill Development Workshop, "A Multiple Intelligences Approach to Conflict Resolution," is designed to inspire school and college counselors to discover a variety of pathways that they can utilize with their clients. It upholds the commitment that we have as counselors to connect with clients using strategies that honor clients as individuals. Emphasizing one or more of Gardner's (1999) multiple intelligences, the activities in the workshop are geared toward stimulating client and counselor awareness of how individuals perceive and react to issues of conflict. The workshop is informed by the research on conflict resolution and multiple intelligences and the presenter's synthesis of these two fields.

Conflict Resolution

Conflict resolution programs encourage the development of useful skills for resolving conflict peacefully that can be applied across the lifespan. Conflict resolution programs in the schools have a wide appeal because of their benefit to students and the school community. These programs can aid students in the following areas: recognizing that conflict is a natural part of life and that it can be resolved peacefully; developing awareness of their own unique responses to conflict and to understand the diversity which with others respond; learning and practicing the principles of conflict resolution and the skills of peaceful problem-solving processes; and empowering themselves to be individually and cooperatively responsible for resolving conflicts peacefully, and to integrate this responsibility in their daily lives (Garner, 2002).

The American School Counselor Association's (ASCA, 2002) position statement on conflict resolution maintains, "A comprehensive conflict-resolution program promotes a safe school environment that permits optimal personal growth and learning. Through participation in a comprehensive conflict-resolution program, students learn skills that maximize their potential for reaching personal goals and success in school."

After over thirty years of research, Johnson and Johnson (1991) concluded that most students do not understand how to resolve their conflicts usefully. They found that students struggle with issues of verbal harassment, verbal arguments, rumors and gossip, and dating or relationship issues. However, there is supporting data that conflict resolution programs can positively impact the school and classroom climate, most strongly when there is an involvement of the total school community (Sandy, 2001).

ASCA (2002) charges professional school counselors to assume the leading role in implementing the essential components of school wide, comprehensive conflict-resolution programs. Because of their specialized expertise, professional school counselors are in a distinct position to facilitate change in the school culture (Hovland, Peterson, & Smaby, 1996).

The Theory of Multiple Intelligences

Howard Gardner, a Harvard psychologist, defines intelligence as, "a biopsychological potential to process information that can be activated in a cultural setting to solve problems or create products that are of value in a culture" (Gardner, 1999, p. 34). Gardner (1983) theorizes that humans have a "range of capacities and potentials," which he called the multiple intelligences.

The original seven intelligences identified by Gardner included linguistic, logical-mathematical, musical, bodily-kinesthetic, spatial, intrapersonal, and interpersonal intelligences. In 1999, Gardner introduced the naturalist intelligence, which involves applying knowledge of the living world and interacting subtly with various living creatures (Gardner, 1999).

Armstrong (1993) reminded educators to realize that we possess all seven intelligences and that we can potentially develop them to a level of competence. He discussed the danger in excluding the other areas of intelligence by focusing on only one area of strength. According to Gardner (Armstrong, 1993), viewing the various intelligences as separate categories is a fiction, as they are always joined together in complex ways in daily life.

The application of Multiple Intelligences (MI) theory is widespread in the United States as well as abroad. A growing body of evidence demonstrates that schools who integrate MI theory tend to report that, "students are more likely to come to school, to like school, to complete school, and to do well in assessments" (Gardner, 1999, p. 112). Levin (1994) reported nearly a decade ago that thousands of workshops on MI theory in classrooms had been given to school staffs and that hundreds of textbooks on the theory and applications were available. There are currently several hundred different interpretations of what MI theory is and how it can be applied in schools (Gardner, 1999). Moreover, formal MI networks have been created to share information and provide access to others interested in MI theory.

"A Multiple Intelligences Approach to Conflict Resolution" united the concepts of multiple intelligences and conflict resolution and integrated them into the helping relationship. The goal was to assist counselors in maximizing their clients' many intelligences, as clients engage in the understanding and resolution of intra- and interpersonal conflicts. The ideas generated from this presentation can be used by school and college counselors with individual clients, in group settings, as well as infused into a comprehensive conflict resolution program.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 *Winter 2003*

Art Therapy Techniques: Couples and Commitment

Abstract

Nina Denninger

The theme of the 2002 Pennsylvania Counseling Association Annual Conference is *Valuing Commitment*. Perhaps in no arena is a clear expression of one's honest thoughts and feelings about the concept of commitment more desirable than in couples counseling. Art therapy techniques provide quick and easy access to unconscious feelings related to being in a committed relationship; such information is useful for clients and therapist alike.

Workshop participants gained an understanding of the thought process leading to a specific, structured directive for art therapy in couples counseling. Theoretical underpinnings from the disciplines of Emotionally Focused Marital Therapy (EFT) (Johnson, 1996), Phenomenological Art Therapy (Betensky, 1995), Gestalt Art Therapy/Personal Construct Theory (Rhyne, 1973) and Art Psychotherapy (Wadeson, 1980) were overviewed. The interdisciplinary nature of art therapy practice was explained and the rationale for and development of a specific, structured directive were illustrated.

Workshop participants experienced a structured directive and practiced verbal responses to the artwork produced, based in Art Therapy and Emotionally Focused Marital Therapy practice. Effective art therapy practice requires first-hand experience with the directives suggested to clients. Participants produced ***abstract images of their concepts of "commitment"***. Thus, they experienced the power of engagement with materials and how the creative processes tap into the unconscious affective components of an individual's experience. These components are not necessarily accessible through verbal modalities. Abstract imagery (as opposed to literal or symbolic imagery) sensitized participants to the phenomenological approach to viewing client productions exemplified in the work of Betensky (1995).

Effective art therapy practice also requires responding, verbally, to clients' imagery in an empathic manner that fosters insight and emotional engagement. Participants acquired an awareness of the deceptively simple art therapy approaches espoused by Betensky (1995) and Rhyne (1973). Both approaches require the therapist to suspend all pre-conceptions about possible "meaning" in a client's work, while at the same time bringing an expert sensitivity to the phenomenology present in the work. In her work, ***What do you see? Phenomenology of therapeutic art expression***, Betensky (1995) provided specific questions prompting clients to engage with the lines, colors, shapes and repeating patterns in both their own work and the work of their partners. These questions focus on the possibilities for greater self-knowledge offered by the structural components of the artwork more so than the literal content presented. A key hypothesis of Betensky's (1995) work is that the structural components of the art can represent the inner reality of the client more accurately and more acutely than the content.

Participants became familiar with the response techniques espoused by Johnson (1996) and Johnson and Greenberg (1992, 1994, 1995) in their works on Emotionally Focused Marital Therapy (EFT).

- *EFT looks within and between*. "It integrates an ***intrapsychic*** focus on how individuals process their experience...with an ***interpersonal*** focus on how partners organize their interactions into patterns and cycles" (Johnson, 1996, p.5). The process of experiencing and interacting are touchstones for the therapist, as he or she attempts to guide the couple to increased sensitive responsiveness.
- *EFT expands experience and interactions*. "The first goal of therapy is to access and reprocess the emotional responses underlying each partner's interactional position, thereby facilitating a shift in these positions toward accessibility and responsiveness..." (Johnson, 1996, p.5).

In EFT, the therapist observes and brings to light rigid patterns of behavior that the couple developed over time in response to unacknowledged, underlying fears. Exposing these patterns and the emotional basis for them enables couples to express themselves in new ways that reflect each partner's felt vulnerabilities more accurately. Establishing mutual vulnerability as well as mutual care and concern facilitates both greater responsiveness and a mental and emotional climate for more receptive, empathic and supportive interactions.

Emotionally Focused Marital Therapy (EFT) and art therapy are natural theoretical partners, since each emphasizes heightened and empathic awareness of personal experience, the experience of one's partner, and the impact one's own experiences and perceptions are having on one's interpersonal interactions, particularly in the couple relationship. Experiential activities are germane to both approaches. EFT and art therapy share several experiential tenets, including the following articulated by Johnson (1996):

- Human beings are constantly processing and constructing their experience and symbolizing their experience. The client, not the therapist, is the expert concerning his or her own experience. The therapist's role is to help the client expand awareness of that experience, integrate aspects that were excluded from awareness, and create new meaning frameworks.
- The therapist is the creator of safety, fostering intense and new experiences. The therapist is also a process consultant, helping the client contact, explore, symbolize, and integrate new experience. Change occurs in the session, in the present, as a result of the expanded processing of experience and the generation of new experience. This subsequently modifies emotional schemes.
- The therapist directs the client to engage in tasks that foster a new kind of processing of experience, such as attending to new elements in a problematic reaction (e.g., the stimulus or trigger, rather than the reaction itself). This awareness broadens and deepens until new facets emerge that reorganize the experience as a whole.

The marital (EFT) therapist facilitates this experiential process primarily with verbal responses, focusing and shaping the nature of the couple's interactions. The art therapist does this by encouraging the couple to understand and decode the phenomenology present in their artwork in order to appreciate the ways they structure and symbolize their experiences. The methods are different, but the rationale and goals are the same.

Why use art in the process?

Most couples seeking counseling are well defended in their verbal exchanges and entrenched in their interactional patterns. They are largely unconscious of the intrapsychic and interpersonal dynamics contributing to the distress they are experiencing.

Among the many issues each member of the pair brings to the relationship is a host of preconceptions about coupling. This includes each partner's conscious and unconscious definitions of commitment and what role commitment plays (or ought to play from his/her perspective) in the relationship. Preconceptions are shaped by both personal experience and perceived societal expectations.

Married couples in particular, who have taken vows such as "until death do us part" may be operating, perhaps unconsciously, under societally imposed mental constrictions that don't permit genuine access to any complex or ambiguous feelings they may have about being in a committed relationship. Gaining access to the couples' genuine individual feelings and thoughts about how to conduct a committed relationship (and other related concepts) may prove difficult when using only verbal exchanges, which can be well scripted and unintentionally rehearsed. Verbal exchanges between the couple may be scripted because they allow each individual to remain guarded and defended and unintentionally rehearsed because couples in distress tend to fall into rigid, repeated patterns of communicating. Creative arts therapy techniques have been demonstrated to tap into deeper, less defended levels of affective functioning (Adamson, 1984; Allen, 1995; Betensky, 1995; Landgarten, 1981; Lusebrink, 1990; McNiff, 1989, 1992; Moon, 1990; Naumburg, 1945, 1953a, 1953b, Rhyne, 1973; Robbins, 1989; Rubin, 1984; Schaverein, 1992; Ulman & Dachinger, 1975; Wadeson, 1980, 1987). Also, creative art therapy techniques can be used to advantage by sensitive counseling and psychotherapy practitioners as well as by art therapists.

The advantages of using art in psychotherapy include:

1. Creative art processes tap into primary process material and transcend verbal censorship. "Art is a less customary communicative vehicle for most people therefore less amenable to control" (Wadeson, 1980, p.9).
2. Art making provides an alternative avenue for communicating thoughts and feelings. Cromwell and Peterson (1983) and Grotevant and Carlson (1989) stressed the value of multiple methods of assessment. It logically follows that multiple methods of self-expression in the therapeutic process should be equally valued. Self-reports are often tainted by what clients perceive to be expected socially acceptable responses. The unfamiliarity of expressing oneself through art materials avoids this dilemma.
3. Images remain for the makers to explore. There is far less dependence on the therapist's recollection or interpretation of interactional events. The images remain to be reexamined at later dates.
4. Clients can gain some objective distance from themselves and their feelings in order to take ownership of them. "A particular advantage of there being a tangible object produced is that it is often easier for a resistant patient to relate to the picture than to the self...I call this process 'objectification' because feelings or ideas are at first externalized in an object..." (Wadeson, 1980, p.10).

5. Multiple levels of meaning can be derived from a single piece, and a creative piece can contain contradictory messages, more accurately reflecting felt experience than can be described in words. "Verbalization is linear communication. First we say one thing, then another. Art expression need not obey the rules of language—grammar, syntax, or logic. It is spatial in nature" (Wadeson, 1980, p.11).
6. Both members of the couple are given "voice" simultaneously. Sometimes, the perspective of one partner dominates a clinical interview (Hawley, 1995). Engaging each member of the couple in either independent or joint art processes serves as an equalizer, allowing both members of the couple equal opportunity to participate in the counseling process.
7. Clients gain insight when they learn a new way of viewing themselves and their partners. "Through the act of looking at their own art work new facets of self become apparent to the art makers and new communication takes place between the artwork and the subjective experience of the client-turned-to-beholder" (Betensky, 1995, p.12).

The Structured Directive

Each member of the couple is provided with a box of 8 or 12 oil pastels (one complete box per person) and each receives a large square sheet of white drawing paper (12" X 12" or larger). They are invited to use only lines, shapes, and colors to express their ideas and feelings about the word commitment. Upon completion of the pieces, the art is placed at a distance and clients are encouraged to "be with" the art in silence for a brief period. They are then encouraged to tell what they see in their own and each other's work. The questions posed by the therapist and the shaping of the ensuing discussion are guided by Betensky's (1995), Rhyne's (1973), and Johnson and Greenberg's (1995) theoretical approaches.

The goals of the process are to: (a) shed light on each partner's unconscious relationship to the concept of commitment, (b) explore how each feels about his/her own and his/her partner's concept of commitment, (c) appreciate how these concepts and related feelings may be shaping the current distressed relationship, and (d) use this new understanding to heighten mutual vulnerability, responsiveness and emotional accessibility.

The expectation is that the phenomenology that appears in the artwork will present the makers with new information about themselves (using a phenomenological approach to art therapy) and that the therapist will facilitate interactions around this emerging information in such a way as to foster greater emotional engagement. This follows the Emotion Focused Therapy Model. Ideally, the process will provide the distressed couple with opportunities for witnessing each other in new and more intimate terms, view each other form more receptive positions, and foster greater intimacy because of a heightened awareness of their shared commitment to their relationship.

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Counseling Adolescents with Eating Disorders

Abstract

Laurane McGlynn

Eating disorders are the third most chronic illness among American adolescent females. Eating disorders are pervasive and long lasting. Although there is no cure, treatment can offer symptom relief and the opportunity to formulate a recovery plan.

During puberty, adolescents experience an increase in body fat that can lead to heightened body dissatisfaction resulting in the development of disordered dieting which can lead to an eating disorder. Girls between 8th and 9th grade represent the largest increase in disordered dieting (Lippincott, Williams & Wilkins, 2000).

Developmental issues such as peer pressure, establishing and experimenting with sexual relationships and separation and individuation from family all contribute to the onset of eating disorders. Problems associated with changes in friendships and/or social support networks, as well as increasing academic demands and heightened societal pressures can trigger disordered eating behaviors (Stein, Saelens, Douchis, Lewczyk, Swenson & Wilfley, 2001).

When developing a treatment plan there are two distinct issues to consider: food and weight issues and other psychological or familial issues (National Eating Disorder Information Center, 1996). During treatment, the counselor and client work together to restore healthy eating patterns, address dysfunctional behaviors, improve associated psychological difficulties, enlist family support and prevent relapse. Counseling can also assist the client in working through interpersonal concerns such as low self-esteem, perfectionism, fear of maturation, societal pressure to be thin and family conflicts.

The complex interaction between developmental, familial and cultural factors can yield important information in understanding the interplay of co-morbid pathologies as well as individual risk factors. Common factors found to predispose individuals to developing eating disorders include low self-esteem, depression, anxiety, perfectionism, dysfunctional families or relationships, impulsivity, genetics, trauma and stress (American Psychological Association Help Center, 2002; Killen, 1993; National Eating Disorders Information Centre, 1996). One or more of the following co-morbid conditions can exist in the client's profile: depression, obsessive-compulsive disorder, alcoholism or substance abuses, post-traumatic stress disorder and attention deficit disorder (Killen, 1993). Eating disorders manifest as a result of social, cultural, family and biological variables. In developing treatment plans, it is necessary to consider all diagnostic issues that potentially affect the client.

Prevention is an important strategy to prevent the development of eating disorders. When adolescents exhibit certain problematic behaviors such as strict dieting for weight loss, occasional binging and/or a dramatic increase in exercise, these are cues that potentially and eating disorder may be developing. Seeking professional help is indicated when eating behaviors destructively impact behavioral functioning or self-image (American Psychological Association, 2002).

Classification of Eating Disorders

According to the DSM-IV-TR (American Psychiatric Association, 2002), there are three major categories of eating disorders: Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified (including Binge Eating Disorder).

Individuals with Anorexia Nervosa are 15 percent below expected normal weight. They may refuse to eat (restricting type) or engage in purging behaviors such as self-induced vomiting, the use of laxatives, diuretics or enemas or exercising compulsively (binge-eating/purging type). These individuals may be extremely afraid to gain weight despite the fact that they are underweight, experience a distortion of body weight and shape, may participate in eating rituals and/or experience amenorrhea (in post-menarcheal females).

Diagnostic features of Bulimia Nervosa include eating excessive amounts of food in a relatively short period of time and a sense of lack of control during the episode. Following the binging episode inappropriate purging behaviors occur. These compensatory purging behaviors include the use of laxatives or diuretics, vomiting and/or exercising excessively. Individuals with Bulimia Nervosa often determine their self-value through their body shape and weight. Other symptoms of bulimia include frequent overeating when distressed, binging on high calorie sweet foods, planning binges or opportunities to binge, depressive moods, feeling out of control and expressing shame or guilt about eating.

The primary diagnostic feature of Binge Eating Disorder (BED) is eating, in a discreet period of time, an amount of food that is larger than most people would eat in a similar period of time and lack of control during the episode. The episodes are associated with eating rapidly, without regard for hunger, until uncomfortably full; eating alone because of feeling embarrassed regarding the quantity of food consumed; and/or feeling disgusted, depressed or guilty over eating.

Treatment of Anorexia Nervosa

Stein and colleagues (2001) concluded that family therapy is the best treatment approach for women with early onset and a short duration of Anorexia Nervosa (AN). Much of the literature on family therapy conceptualizes the family's role in contributing to and perpetuating Anorexia Nervosa. The family therapy approach theorizes the problem as belonging to the whole family and aims at treating the entire family system. Family counseling helps resolve co-existing family conflicts and gives parents the opportunity to understand the eating disorder from their adolescent's perspective.

The Maudsley model of family therapy has shown the strongest support in treating Anorexia Nervosa. This family therapy approach focuses on the role of eating disorders in inhibiting, complicating and disturbing the developmental processes of adolescents (Lock & leGrange, 2002). At a one-year follow-up, Eister, Russell, Szmukler, leGrange and Dodge (1997) reported that this treatment intervention demonstrated efficacy in approximately two-thirds of the AN patients.

The Maudsley model of family therapy postulates that individual, family and sociocultural influences interact to maintain anorexia (Dare & Eisler, 1997). This model is unique in that it does not view the family as pathological; rather, it postulates that the family is a resource to recovery. Treatment techniques include family empowerment, a non-authoritarian therapeutic stance, the use of family meals and externalizing the illness for both the client and the entire family (Lock & leGrange, 2002).

Family empowerment begins with a family meeting during which the parents are instructed to develop an alliance and assume responsibility for their child's nutrition. The primary foci are the re-feeding process and restoring and maintaining physical health. Once steady weight gain is achieved, the child resumes control of their eating. A non-authoritarian approach to treatment encourages personal autonomy of the adolescent and helps develop healthy, appropriate boundaries within the family. The therapist conducts family meals to observe eating patterns and family interactions. Treatment focuses on alleviating disordered eating behaviors, developing family boundaries and maintaining the steady weight gain and health of the child.

Treatment of Bulimia Nervosa

Bulimia Nervosa (BN) is the most widely studied eating disorder. In treating bulimia, two kinds of therapy have been effective: cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). The cognitive model of bulimia offers five core domains that perpetuate the disorder. Factors that influence the maintenance of BN are low self-esteem, extreme dissatisfaction with weight and shape, dietary restriction, binge eating and self-induced vomiting. CBT works to change maladaptive thinking patterns and behaviors while IPT focuses on altering personal relationships and losses and improving interpersonal relationships. Interpersonal therapy hypothesizes that interpersonal functioning and its relationship to psychological adjustment is directly related to the development of the presenting eating disorder (Fairburn, 1993). Identifying the connection between disordered eating and interpersonal problems assist the client in developing supportive relationships, enhancing self-esteem and improving mood. As these changes occur, binge eating, compensatory behaviors and inappropriate attitudes toward eating, weight and body shape improve (Fairburn, 1993).

Treatment for Binge Eating Disorder

The vast majority of research on the treatment of Binge Eating Disorder (BED) focuses on the use of cognitive-behavioral therapy (CBT). CBT postulates that controlling weight with chronic dieting promotes and maintains binge eating. CBT works on decreasing dietary restraint and establishing regular, healthy eating patterns.

Several characteristics of binge eating disorder such as concerns about weight and shape, low self-esteem and negative affectivity are conducive to cognitive-behavioral treatment strategies. The focus of cognitive-behavioral therapy for BED is restructuring the thought patterns associated with the diet/binge cycle. This results in changing chaotic eating patterns and moderating food intake. Key treatment issues include exploring thoughts and attitudes toward food, eating, body weight and shape. Treatment goals involve self-acceptance and modification of stereotypical socially accepted weight and image. Encouraging an increase in physical activity and developing an exercise regime would be practical recommendations.

Obesity – The other eating disorder

Psychological damage is an unfortunate consequence of unsuccessful dieting. The fact is that most eating disorders start with a diet. In treating overweight adolescent clients, counselors need to focus on strategies to improve physical and psychological health. Self-care and acceptance of size are empowering and foster emotional and physical health.

Effective interventions include encouraging healthy eating and moderate exercise by focusing on the health benefits derived from these lifestyle changes. Treatment of larger adolescents should focus on improving quality of life, finding alternatives for self-nurturance besides eating, relationship building, nutritional education, acceptance of both size and self and maintaining a healthy lifestyle.

Left untreated, eating disorders deteriorate the quality of life and cause serious health complications. As with many diseases and mental illnesses, there are many causes and a multitude of treatment approaches. Flexibility is important when developing an individualized treatment plan. Effectives therapies for working with adolescents with eating disorders include cognitive/behavioral, psychodynamic and psychoeducational approaches. Certain interventions may fail while others may be optimal, depending on many different variables involved in each case. These different factors include the client's behavioral features, the complexity of biological and environmental factors, level of functioning, cognitive abilities, family dynamics and available support systems. A plan aimed at symptom reduction and alleviating injurious behaviors can lead to recovery by finding a balance among the physical, mental, emotional, environmental and social aspects of adolescent life.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 *Winter 2003*

Gatekeeping: Preparing Quality Counselors

Abstract

Jay Darr, Holly Moore and Chad Snyder

Bernard and Goodyear (1998) describe education and supervision as having evaluative aspects and ultimately serving the gatekeeping function of determining who is legitimized to enter the world of work in their chosen area. Increased standards regarding counselor education have been set by professional organizations such as the American Counseling Association (ACA) (1995), Association for Counselor Educators and Supervisors (ACES) (1993), and Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) (1994).

Academic and clinical competences as well as personal stability provide a host of complex legal and ethical issues for graduate counselor education programs to take into consideration when gatekeeping for impaired students. If appropriate evaluative criteria are not in place and a student is dismissed from the program for not possessing the ability to provide competent service, the faculty and institution may face legal recourse from the student. This concern is even more worrisome if the student maintains the appropriate grade point average.

A current literature search identified four published graduate counseling gatekeeping models, all designed in graduate counseling programs in the United States. . These models are a reactive attempt to increase attention and knowledge regarding ethical and legal issues concerning gatekeeping in the counseling field. This abstract reviews the development of the gatekeeping function via these published models in order to identify reasons for their development and key points of each, including strengths and weaknesses. Furthermore, suggestions to improve these gatekeeping models of counselor education are provided.

Key Legal Concerns in Gatekeeping

Olkin & Gaughen (1991) reaffirmed four major points from key gatekeeping cases. First, the courts are reluctant to consider and overturn professional decisions made by qualified faculty. Second, interpersonal skills, hygiene and attitudes may be included within the academic domain. Third, institutions may delay acceptance decisions and graduation in order to offer remediation. Finally, it is the role of the school to provide due process by informing students of performance problems and the consequences of such problems. Institutions must ensure that dismissal decision-making is careful and deliberate and not arbitrary and capricious.

Even though many gatekeeping cases are medical school related, they are relevant to clinical programs (such as counselor preparation) because they involve both academic- and performance-based evaluations. Thus, these cases provided the legal precedents for future litigation regarding dismissal from professional training programs. More importantly, these cases provided a framework and motivation for institutions to be proactive in their design and implementation of clinical training programs that not only honor due process, but also honor the students' and faculty's cultural, academic and professional needs.

Key Ethical Issues in Gatekeeping

Ethical concerns in gatekeeping are relevant to counselor education programs in order to maintain integrity and professionalism. The American Counseling Association (ACA) Code of Ethics and Standards of Practice (1995) requires counselors to refrain from offering "...professional services when their physical, mental, or emotional problems are likely to harm a client or others" (Section C.2.g). In Section F.2.a and b, ACA (1995) further calls counselor education and training programs to inform students of all program expectations, evaluation processes, and dismissal policies and procedures prior to admission. The Association of Counselor Educators and Supervisors (ACES) (1993) requires supervisors to be aware of personal and professional limitations of students and to recommend remedial processes to deal with those limitations (Section 2.12). Additionally, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) (1994) requires students to demonstrate effective interpersonal relationships and openness to self-examination.

Overall, ACA (1995), ACES (1993) and CACREP (1994) provide ethical rubrics in terms of trainee and professional self-examination. Additionally, these professional codes outlined the professional responsibility of the supervisor and the training body to assure that students and professionals are appropriately trained to meet the standards of the counseling enterprise. However, none of these ethical codes or standards articulated procedural guidelines for assessing abstract personal attributes that are often relevant to gatekeeping issues (Bemak, Epp & Keys, 1999).

Review of Published Gatekeeping Models

Frame and Stevens-Smith (1995) reported on a gatekeeping model developed by the Counseling Psychology and Counselor Education Division at the University of Colorado at Denver. Frame and Stevens-Smith (1995) stated several reasons for the development of this model, including the ethical mandate of counselors to do no harm, a recognition of the power of the therapist's interpersonal influence, the obligation of counselor educators and supervisors to monitor students' personal and professional development, and legal repercussions associated with the lack of gatekeeping. Additionally, the Frame and Stevens-Smith (1995) model established a continuum of impairment, utilizing a 5-point Likert-type instrument, the Personal Characteristics Evaluation Form (PCEF). This standardized form was based on the faculty's belief in nine essential functions of personal characteristics in the development of ethical and competent counselors. The PCEF was used at midterm and finals in each class in the Counseling Psychology and Counselor Education Division at the University of Colorado at Denver with negative evaluations initiating the gatekeeping process.

In 1997, Baldo, Softas-Nall and Shaw suggested an alternative to the Frame and Stevens-Smith (1995) proposal based on a model developed by the Division of Professional Psychology (PPSY) at the University of Northern Colorado (UNC). This model responded to a key limitation of the Frame and Stevens-Smith (1995) model in that faculty members may become the focus of student's feelings of aggression because of attributing their failure in the program to a negative evaluation by faculty members. Thus, Baldo et al. (1997) encouraged the use of a faculty review committee, in conjunction with the entire counseling faculty in order to lessen the individual responsibility of a faculty member. The model included a Student Review and Retention Policy.

In 1999, Lamadue and Duffey described a model developed by the faculty at Southwest Texas State University (SWT). This model progressed from the previous models by offering a behaviorally specific student evaluation instrument, the Professional Performance Fitness Evaluation (PPFE) assessing five major areas: counseling skills and abilities, professional responsibility, competence, maturity, and integrity. The PPFE was based on competencies outlined in the ACA (1995) Code of Ethics and Standards of Practice and included specific behaviors rather than the abstract characteristics listed by the 1995 Frame and Stevens-Smith model.

Similar to the Southwest Texas State University model, Bemak, Epps, and Keys (1999) suggested informing students of gatekeeping procedures prior to program admittance. The notification is backed up by a requirement for new students to meet with their faculty advisor upon admission to plan coursework and review the evaluation process. The student also signs a contractual agreement in regard to gatekeeping policies and procedures.

Bemak et al. (1999) tied student personal development to grades by integrating skill development and professional behavior as a significant portion of each course grade. Additionally, Bemak and colleagues recommended uniform admission and screening procedures, addressing multicultural issues, and recognizing the importance of communication among supervisors.

Enhanced Model of Gatekeeping

Taking into account legal and ethical concerns as well as the four published models of gatekeeping, this abstract proposed an enhanced gatekeeping model utilizing the acronym "PACE". This enhanced model is a proactive attempt to consolidate and improve previously published gatekeeping models, as well as articulating the components of professional counselor performance. Utilization of this model in counselor education programs could potentially reduce the number of impaired counselors entering the profession.

The "P" in the PACE model most importantly represents the notion of being proactive. Also, the "P" represents the personal development of the counselor in training. This development involves the creation of pre-admission screening and policies/procedures clarifying the skills and competencies required throughout the academic and experiential component of the learning process. Finally, the "P" also addressed having plans for remediation procedures in order to facilitate the impaired students' acquisition of effective skills.

The "A" most importantly represents the process of ongoing assessment. Furthermore, the "A" component refers to assigning a faculty member to update and train other faculty on current legal and ethical issues regarding assessing students' intrapersonal and interpersonal skills. The "A" also stands for the necessity of assigning mentors to new faculty as well as assigning job-shadowing experiences to students.

The "C" addresses clarity in dissemination of the gatekeeping process. The competencies and constructs that define professional performance need to be clearly defined and continually addressed through student assessment and feedback. Also, clear communication and continuous contact between the academic and site supervisor helps the student clarify roles and responsibilities during experiential program components. Open lines of communication between supervisors provide a supportive and conducive environment for students' development of professional skills.

The "E" encompasses the entire experiential training component from the start of the educational process, to the development of student knowledge and skills, to the growth of competent and effective counselors. The "E" component focuses on the acquisition of those professional skills that are not stated in textbooks but acquired through real life situations. Furthermore, the "E" component addresses ways to bring these professional experiences into the classroom. This component includes assigning realistic and applicable experiences that facilitate the students' ability to apply theories and techniques in the actual field setting. The notion of waiting until practicum and internship to address such issues exacerbates the problem of preparing adequate remediation plans.

Appendix

PACE: Proactive Assessment that is Clear and Experiential

P: Proactive movement
Personal Development
Pre-admission screening
Policies/procedures
Plans for remediation

A: Assessment
Assign faculty member to update faculty on gatekeeping literature/litigation
Assign new faculty to mentor
Assign job-shadowing experience

C: Clarity
Clear definitions and constructs
Clear competencies
Clear communication and contact with site supervisor and academic supervisor

E: Experiential
Experiential/reflective coursework
Experience increased client contact observation of live sessions or videotape
Experience of developing treatment plans and goals
Experience of attending meetings and groups
Experience real life situations/cases

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 1 *Winter 2003*

Supervision, or "You Want Me to What?"

Abstract

Paul A. Niemiec

Counseling supervision is a critical component of both counselor training and direct practice. Both trainees and experienced clinicians benefit from opportunities to receive feedback from a more experienced counselor regarding case dynamics, alternative interventions, and the refinement of counseling skills. Supervision is a major venue for both counselor training and safeguarding client welfare. The counseling profession maintains an apprenticeship model of professional preparation in which the novice counselor "learns the ropes" and develops clinical skills under the direction of a more experienced clinician. Also, supervision provides important teaching and oversight roles relative to the counselor's direct counseling interactions with clients.

Consisting of interactions between at least two people, supervision assumes a unique combination of goals. Some of these goals include skill enhancement, client improvement, and client welfare. Supervision combines clinical consultation about clients with both counselor training and evaluation. These multiple activities occur within the relationship between the counselor and the supervisor. This relationship is potentially characterized by different roles and expectations by each of the participants, an unequal power distribution, as well as other elements.

The supervisory working alliance (Bordin, 1983) is a relationship-based model of supervision (Bernard & Goodyear, 1998). It derives from the therapeutic working alliance (Bordin, 1975) and is one of the supervision models based on parallel process theory. Both Bordin (1983) and Watkins (1997) described the supervisory working alliance as applicable across different theories of supervision and supervisor development.

The goals of the supervisory working alliance include counseling skill development, personal and professional growth of the counselor, understanding of clients, ethical practice, learning the concepts and methods of therapy, and dealing with personal and intellectual impediments to counseling (Bordin, 1983; Campbell, 2000). However, the supervisory working alliance is not construed as precisely parallel to the therapeutic alliance. This is primarily because of the different goals of supervision as well as the potentially evaluative role of the supervisor.

The chief elements of the supervisory working alliance include agreements between the supervisor and the counselor about the tasks and goals of the supervision, as well as attention to the inherent emotional bond in the relationship. Relationship development requires a degree of collaboration between the supervisor and supervisee regarding both the purposes of counseling and how therapeutic activities are carried out. The supervisor's responsibility for evaluation of the supervisee also impacts the collaborative supervision relationship. The evaluative component draws attention to a power differential between supervisor and supervisee that may be manifested in passing a course or receiving a promotion or a raise.

The context of the relationship may help influence the supervisory experience of both supervisors and supervisees. Niemiec's (2002) study of the supervision of counselor education trainees using the Supervisory Working Alliance Inventory (Efstation, Patton, & Kardash, 1990) found that certain elements of the supervisory working alliance significantly increased during the training semester, but that others did not. One possible reason for these results is that some factors were rated highly by supervisors from the beginning, so that the ratings did not have significant room for improvement on the measurement scale. Additionally, in both university and clinical practice settings, Bordin (1983) characterized the relationship by a weakening and repair process. This process may be facilitated or hindered by external features of the environment (Burke, Goodyear, & Guzzard, 1998).

Managing the relationship becomes a critical task for the successful supervisor. Campbell (2000) and Niemiec (2002) describe several relationship skills that are important for building and maintaining the supervisory working alliance. These skills include basic counseling skills such as active listening, attentiveness, and availability of the supervisor to the supervisee for consultation. Supervisory style, role conflict and personal factors also impact the supervisory relationship (Niemiec, 2001). For example, different supervisors may approach the supervision setting uniquely. Also, there is potential for supervisor and supervisee to have conflicting role expectations regarding supervision. Personal factors can also affect the supervision relationship. For example, Ladany and Lehrman-Waterman (1999) investigated the relationship among supervisory working alliance, supervisory self-disclosure, and supervisory style. They found that that trainees reported a stronger emotional bond with supervisors who self-disclosed their own counseling struggles. Ladany and Friedlander (1995) studied role conflict among trainees who were required by their supervisors to behave like a colleague and like a client at different times. Ladany and Friedlander (1995) concluded that role conflict could be a pervasive part of the supervision experience for supervisees. This role conflict is best managed by the development of a relationship with a supervisor that demonstrates warmth, trust and empathy. Therefore, it is incumbent for supervisors to manage the supervisory working alliance.

At the start of the supervisory relationship, and typically for some time thereafter, supervisors are in the position of power in the relationship relative to the supervisees. Supervisees are usually incapable of a more collegial or egalitarian relationship with their supervisors until they are more advanced in their professional development (Stoltenberg, McNeill, & Delworth, 1998). Supervisors might prepare for new supervision relationships by identifying their own positive and negative experiences in supervision and conceptualizing these experiences in alliance terminology. Supervisors are encouraged to self-assess their relationship building skills and to discuss their findings in their own supervision. With the hectic pace of many counseling settings, carving time for self-assessment and personal reflection is hard to find; yet, critical for building successful working alliances. Feedback from both supervisors and supervisees can help supervisors increase their skills that foster collaboration. Supervisors can develop strategies that implement the agreements needed for supervisory relationships as well as the mutuality and collaboration that facilitate useful supervision.

Within the model of the supervisory working alliance, after the collaborative framework is established, the relationship requires maintenance, including a periodic checking back between both partners (supervisor and supervisee) as to the usefulness of the collaboration. Corrective feedback to the supervisee or challenging patterns of supervisee behavior entails challenging certain supervisory behaviors as well. The supervisory working alliance provides a theoretical framework within which the supervisory relationship can be managed and flourish, with beneficial results to supervisees, clients, and the supervisor.

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1. Manuscripts should not exceed 20 pages.
2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) on 81/2 x 11" nontranslucent white bond with 1 1/2" margins on all sides.
3. The title page should include two elements: title, and author affiliation. Identify the title page with a running head and the number 1 typed in the upper right-hand corner of the page.
4. Begin the abstract on a new page, and identify the abstract page with the running head and the number 2 typed in the upper right-hand corner of the page. The abstract should be approximately 125 words.
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The Journal of the Pennsylvania Counseling Association (ISSN 1523-987X) is a biannual publication for professional counselors. It is an official, refereed branch journal of the American Counseling Association, Inc.

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The Journal of the Pennsylvania Counseling Association

Andrew L. Carey and
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Volume 5, Number 2 Summer, 2003

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Cover Design and Graphics: Kurt L. Kraus, Assistant Professor, Shippensburg University, Shippensburg, PA. Special thanks to Johanna Jones for the typeset.

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The Journal of the Pennsylvania Counseling Association

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Apology to Author

We want to extend our sincere apologies to Dr. David J. Tobin for our omission in the previous issue of JPCA (Volume 5, Number 1, Winter, 2003) of his biographical material that normally follows an author's article. Dr. Tobin's article was "Countertransference and the Hidden Client in Counselor Training and Supervision." The biographical information that was to follow the article is: Correspondence concerning this article should be addressed to Dr. David J. Tobin, Ph. D., Community Counseling, Gannon University, 109 University Square, Erie, PA 16412. Again, we are sorry for the oversight and appreciate his valuable contribution to JPCA.

A Case for Spirituality: Beyond the Human Level

Andrew L. Carey
LeeAnn Eschbach

Within the last decade, counseling professionals have increasingly acknowledged the need for counselors to be able to deal effectively with client spirituality as seen by the results in Kelly's national study (1992, 1994), Pate and High's national study (1995), and by the inclusion of spirituality in the Council for the Accreditation of Counseling and Related Educational Program's (CACREP, 2001) standards. When client belief systems are significantly intertwined with their spirituality, as the above national studies have indicated, counselor effectiveness depends upon counselors' abilities to deal with spiritual beliefs. As this spiritual trend continues, we, as counselors and as persons, must continually open ourselves to more of who we are and who we are to be. How can counselors effectively help clients explore their spirituality if counselors have not explored and faced their own? The more whole we are as counselors, the more effectively we can facilitate client wholeness.

Observations from two major figures in the counseling field, Carl Jung and Irvin Yalom, provide impetus for learning more about our spiritual and existential existence as humans. These observations bring to the table some basic questions as stimuli for counselors to confront within themselves and for them to assist clients in dealing with life's difficulties at a spiritual-existential level if they so desire. Carl Jung, founder of Jungian Therapy, observed a spiritual instinct or need that exists in all people's psyche, a need that is not derived from any other need, but exists inherently as part of being human. He believed that to deny the existence of that need is to deny part of one's ability to heal and to become fully functioning and whole (Douglas, 2000; Jung, 1957).

Yalom, an advocate of Existential Therapy, in his work, The Yalom Reader (1998), observed conflict at the core of people's difficulties. This conflict he saw, from his intense work with the terminally ill, as centering on four life issues: death, freedom, isolation, and meaning. While Yalom did not directly connect these areas of human conflict to spirituality or God, by the mere fact that these human conflicts are inherent and apply to all people, wholeness and meaning do not seem fully attainable or explainable at a rational, human level alone. In essence, it appears that Yalom's four areas of ongoing human conflict (addressed below) are not fully resolvable unless wholeness and meaning are sought through spirituality, a Higher Power, or God, as Carl Jung observed is necessary.

On death, if we merely live and die here on this earth, much of life makes no sense at all. Many people late in life experience great despair about whether or not anything they did in life really made any difference. Life, at those times, makes little sense. And death makes no sense. In particular, people with no sense of spirituality or God find no purpose or rationale for death, or death-related events. Without seeking a greater purpose for the existence of death and life's darker events, death has no chance of making sense. For instance, while it is inevitable that we die, Yalom saw that we still desire the control and power to be able to live. He noticed that only when people fully faced this issue of death did they find peace and a clearer understanding of their meaning in life. How can this meaning be found at a human level alone when we will eventually leave humans on this earth and go beyond their awareness and understanding? How can meaning for death be found with humans as the end point?

Our conflicts about freedom are also central to being human. People fight for freedom and typically rebel when someone even communicates with them in a way that leaves them no choice. Desiring freedom is inherent within us. Yet, people seldom behave with a freedom in life, a freedom that is free from concern of acceptance and approval from others. While some gradually grow in their freedom, no one is totally free. We react either by doing what others want so as to be accepted by them, or by doing the opposite as a way of rebellion. As long as we have people as our standards of whether or not we are acceptable, we will remain in this bondage of reacting to others in life as opposed to acting freely. When we do not believe in anything beyond the human level, how can our frame of reference be anything but humans for how we judge ourselves, and therefore, how we react. How can the freedom to act, instead of react, be obtained at a human level alone? How can this drive for freedom that is inherent within us be fully found with humans as the standard and end point?

Isolation is another conflict inherent to being human. We want to be free to be who we are and to have our own identity, and yet, we long to be connected relationally. Even from our mother's womb, we were made dependent upon another (our mothers) as a source of life. Dependence upon a source of life beyond us is instilled in us even before birth. Then, upon leaving the womb, we continue with an inherent desire to have a connectedness with a source beyond us. Without this connectedness, we are dissatisfied and feel alone. We are created in such a way that we *need* connectedness with someone apart from ourselves, and at the same time, ironically, we are never fully satisfied with our connectedness with people in life. We live with a deep longing for a connection with others that always seems to be unsatisfied in life. Others, invariably, disappoint us at times and cannot fully give us the sense of connection and completeness we need. Emptiness, every so often, creeps up on us. Somehow our connectedness at a human level does not really fulfill us or allow us to grow with the freedom we need to become whole in life. How can this inherent need for connection be fulfilled at a human level when people are imperfect? How can this compelling need within us for connectedness to an other beyond us as a source of wholeness or completeness, given to us even before birth, be achieved with fallible humans as the end point?

Yalom's observation of the importance of meaning also seems unattainable at a rational, human level. Each of us experience many relentless, painful, and confusing events throughout life that, no matter how much we strive for understanding at a human level, logical understanding cannot touch or help. A loved one who dies from cancer, a tragic accident, family who hurts us beyond belief, a child in an extremely painful situation that cannot be altered no matter who tries to help, and ongoing, heart-wrenching suffering in general are only a few examples that demonstrate the futility of finding meaning at a human level. In a world of seemingly senseless events, how can meaning be found at a rational, human level? How can the possibility of meaning even begin in a world full of chaos, confusion, and pain with mere human understanding as the end point?

Yalom's observations of these normal, inherent human conflicts make obvious the futility of trying to find wholeness and meaning apart from spirituality or God. If all humans suffer and are stuck in these core conflicts to one degree or another, then who is really capable or qualified to answer these conflicts for others? We are really all in the same mess that was designed that way for some bigger purpose. These ongoing and unavoidable human conflicts themselves would seem to be a bad joke on humankind if we were somehow supposed to find meaning at a human level. Understanding seems impossible apart from going to a realm or level beyond humans. Yalom's observations very much support Jung's premise that finding wholeness must come from satisfying one's inherent spiritual needs. These observations also indicate that, apart from seeking beyond self and humankind to satisfy our spiritual needs, we may find ourselves constantly restless and distracted in life with our futile strivings at the human level to rise above conflicts that appear to be inherent in design for one purpose . . . finding Greater Meaning.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 2 Summer2003

Promoting Cultural Competence in School Counselors

John McCarthy
Angelina T. Santus

The changing demographics of the nation offer clear changes in the ethnic and racial cultures of students in today's schools. Being a multiculturally competent professional is an increasingly important role for school counselors, and the benefits and importance of such training are outlined. Models of multicultural graduate training for school counselors can include, but are not limited to, separate courses on the subject, integration of multicultural issues throughout the graduate curriculum, and self-assessment instruments.

Introduction

With the rapid increase of ethnic and racial minority cultures in last part the 20th century and continuing into the present century, it is imperative for schools in America to prepare students for healthy interactions, communication, and productivity in order to function in a multicultural society. This article outlines the importance of training for school counselors and methods and ideas through which they can become more multiculturally competent via graduate training, the result of which would add greater insight and knowledge to both them and their students regarding cultural issues.

Background

Brislin (1993) defined culture as consisting of "values, ideals, and assumptions about life that are widely shared among people and that guide specific behaviors" (p. 4). The inherent challenge in understanding culture—one's own or others—is that this concept has an element of "invisibility" (p. 4). That is, many assumptions and ideals are rarely clear, as they reside in a person's mind and are not often open for others to see and hear. Furthermore, Brislin also pointed out that many people do not get ample opportunities to explore their cultural backgrounds.

Two benefits to such self-examination, however, are plainly evident. First, exploring one's cultures enables individuals to increase insight into the assumptions and values that Brislin mentioned. In addition, cultural exploration can lead to a greater understanding of a family's traditions, community orientations, and spiritual/religious beliefs. Second, having a sense of oneself culturally can lead to a greater understanding of and perhaps willingness to explore other cultures. In far too many cases, people either judge or seek to examine other cultures without having a clear idea of their own cultural beliefs, and the result is often one of confusion and anger, which in turn can lead to prejudice, discrimination, and intolerance.

In school settings, for instance, enculturation—the learning of one's own cultures—takes place for students from the dominant culture. In a country with the social and cultural diversity that our country possesses, acculturation—learning others' cultures—is also an integral part of the educational process (Pai, 1990). What is imperative in such institutional settings is that the various behavioral and thinking patterns of children from ethnic and racial minority cultures not be viewed as a deficit or weakness. Pai continued, "...unless these children are taught about the differences between the dominant and their own cultures and what standards of behavior are appropriate in school, they are likely to be treated as problem cases requiring disciplinary... measures" (p. 39).

For those coming from traditionally dominant cultures, such as European-American culture, the learning of minority cultures is a process that has received more attention in recent years. Prompted by changing demographic patterns among other factors, the need for multicultural training and sensitivity is vitally important for school counselors, and many counseling programs, though not all, require at least one course in this area. Within the past decade, the American School Counselor Association (ASCA, 1993) indicated that professionals should have the "skills necessary to foster increased awareness and understanding of cultural diversity existing in the school community" (Holcomb-McCoy, 2001, p. 196).

One danger in the absence of multicultural training is the use of approaches that may not be consistent with students' cultures. Often, common goals of counseling with European-American, middle-class clients include outcomes such as self-reliance, individuality, and independence (Gladding, 1997). It is important for counselors to understand that goals and techniques based on "basic" values are not acceptable and/or will not be successful with clients of other ethnic backgrounds. Yagi (1998) pointed out specific concerns of various ethnic groups, as he suggested that children and youth of Hispanic descent are more affected by cultural issues of acculturation, immigration, and economic variables, while youths of African-American descent are concerned with social issues of racism, economic deprivation, religion, and family roles. Yagi also added that students of Asian-American descent have "strong cultural elements of family, extended family, gender differentiation, role delineation, religion, tradition, custom, language, and identity" (p.2).

Not only do different cultural groups have distinct beliefs and values, but also each has counseling approaches that may be more effective than those assuming or based on European-American culture. Hispanic adolescents work well with counseling methods that include language acquisition, school achievement, and career development, while, when counseling African-American students, techniques that include group counseling, mentoring, and role modeling work effectively. Counselors also need to be well educated on Asian culture when working with Asian-American students, due to their cultural variables and communication styles having the potential to be different from those of European-American, middle-class youth (Yagi, 1998). Counselors often report utilizing counseling methods such as group counseling, family counseling, and creative arts activities when working with students of Asian descent (Yeh, 2001).

Whether school counselors have received academic training to facilitate such awareness, Hobson and Kanitz (1996) warned that they will inevitably face increasing demands to work with students from culturally diverse backgrounds. This challenge requires counselors to "reassess their professional attitudes and behaviors and take action to ensure that they have the awareness, knowledge, and skill to deliver services to all students" (Lee, 1995, p. 189). For school counselors then, the issue becomes one of ethics. To be ethical in the school setting, counselors must ensure that they have sufficient multicultural training (Hobson & Kanitz, 1996).

How well this ethical dilemma is being met, however, is unclear, for a paucity of data is available on school counselors' multicultural competence. Those counselors without training may not have developed required multicultural skills. The amount of multicultural coursework taken by an individual has been found to be predictive of perceived competence among female school counselors. With others, however, the lack of multicultural training may be a limitation in working with students who are ethnically and racially diverse (Constantine, 2001).

Holcomb-McCoy (2001) found high self-perceived levels of multicultural competence among elementary school counselors. Areas of highest competence were in multicultural terminology and awareness, while multicultural knowledge and racial identity dimensions were rated lowest. She pointed out the importance of this finding, noting, "...it is critical for school counselors to begin conceptualizing multicultural competence in dimensions rather than one entity" (p. 199). Finally, another noteworthy finding is that years of professional experience had no significant effect on the participants' perceived multicultural competence.

Regardless of training, it is imminently clear that the promotion of cultural diversity is one vital role of school counselors. Harris (1999) called it among the most significant of responsibilities, adding that a positive learning environment is created when all racial and ethnic groups are valued and honored. This responsibility is shared with school administrators, and both groups can be aided in this area by conducting a cultural self-analysis, a challenging process by which cultural-self awareness can be built and heightened. A possible first step could be growth in awareness of other cultures, which would take careful analysis and involve an investigation of a racial development identity model (Atkinson, Morten, & Sue, 1993). A myriad of such models exist that are specific to various racial/ethnic backgrounds. Such models can include (but are not limited to) identity development for those of African-American (Cross, 1971, 1995), Asian-American (Lee, 1991), and Hispanic-American decent (Ruiz, 1990). Taken together, these models suggest five common stages in racial identity formation, which can include: conformity; dissonance and appreciating; resistance and immersion; introspection; and finally, integrative awareness (Atkinson, Morten, Sue, 1998). It is also important to note that White racial identity development models have been developed. The Helms model consists of two main phases: abandonment of racism and defining non-racist White identity (Helms, 1995).

In addition to helping with cultural self-awareness on the part of school professionals, awareness of and familiarity with such models can also assist them in better responding to culturally diverse students and their specific psychosocial needs. In essence, these professional must become cultural brokers who have the duty to develop connections among the cultures of students, parents, and the school itself (Harris, 1999).

Multicultural Training for Counselors

Various ideas and methods have been proposed as ways to enhance cultural competence among counselors. The concept and direction of multicultural training is admittedly a challenge. As Pedersen (2003) pointed out, "Just as multicultural schools are complex but not chaotic, so should multicultural training in schools be guided by a sequence of learning objectives that reflect the needs of both the student and the multicultural context" (p. 193). Furthermore, the training needs to be thorough enough to include perspectives that are both general and specific to cultures, while experiential and didactic avenues must be incorporated (Pedersen, 2003). A five-stage approach is highlighted by activities based on awareness, knowledge, and skills. The process is one of 1) an initial needs assessment to prioritize goals; 2) the setting of appropriate objectives; 3) the development of a program to show how objectives will be met; 4) implementation of the plan; and 5) evaluation of the objectives on awareness, knowledge, and skill (Pedersen, 2000).

Though not addressing school counselors specifically, Herring (1998) outlined four ideas, the first of which was the development of a uniform typology for school counselor training programs. No standardized plan currently exists for educating professionals on multicultural counseling, though models in counselor education presently exist. They include the offering of a single course or the blending of multicultural content throughout the curriculum (Lee, 1999). Universal agreement on a specific model would be ideal, yet perhaps is impossible because of the difficulties of the standardization of one particular model and/or format.

Herring also emphasized the need for faculty at training programs to engage in a self-examination process to assess the "cultural appropriateness and relevance of the training program's policies and practices" (p. 5). A part of this process can include the Multicultural Competency Checklist, a practical guide in multicultural curriculum development for use in counseling training programs (Ponterotto & Alexander, 1995). This Checklist, consisting of 22 items with 6 categories, is to be completed either by a director or the faculty as a whole.

In addition to examining training programs, it can be equally important to assess professionals in the counseling field on their multicultural competency. Two methods of multicultural competency instruments used to self-assess are the Multicultural Awareness/Knowledge/Skills Survey (MAKSS) and the Multicultural Counseling Inventory (MCI). The MAKSS is a measure that consists of two sections: a demographic segment regarding sex, age, race, cultural background, education, occupation, and income; and a portion containing 60 items to assess self-reported proficiency in multicultural awareness, knowledge, and skill (Steward, Wright, Jackson, & Jo, 1998). The MCI, on the other hand, is composed of 43 statements within 4 subscales that measure multicultural counseling competence (Ponterotto & Rieger, 1994). Much like the MAKSS, the MCI also assesses capabilities in multicultural awareness, knowledge, and skill. A distinctive feature of this instrument is its fourth subscale, Multicultural Counseling Relationship, which represents the counselor's stereotypes and comfort level with minority clients.

Third, Herring (1998) offered the idea of continual assessment as another way for counselors to improve upon their cross-cultural counseling. Ways to implement this possibility include the use of comprehensive examinations, case studies, and presentation of ethical dilemmas.

Last, some methods of incorporating diverse experience into professional skill may include having students attend professional workshops, counseling multicultural clients, and having access to cross-cultural supervision and internship experiences (Lee, 1999). Integration of experiential activities and minority guest speakers are also highly effective means of stimulating multicultural awareness.

When counseling students, professionals, and counselor educators address multicultural competencies in the field, they are making an ethical decision to take action against multicultural ignorance. They are ensuring that they will deliver their highest level of competence possible to clients of all cultural backgrounds. As this country's demographics continue to change, counseling professionals will experience an increased need for furthering their education and experiences in order to be cultural connectors in their services.

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A Comparison Between African Americans and European Americans in the Vocational Rehabilitation System after the Initiation of the Individual Plan for Employment (IPE): Are there Really Differences?

Keith B. Wilson

The purpose of this study was to identify reasons for closure among accepted African Americans and European Americans after their Individual Plan for Employment (IPE) was completed. The author used a Chi-square test of independence to examine the reasons for unsuccessful closure after being found eligible for vocational rehabilitation (VR) services among African Americans and European Americans with disabilities. The study utilized the Cramer's V to test the strength of the association between independent and dependent variables. Using these test statistics, the author found race and reason for closure to be significant and only slightly associated. African Americans were more likely to be categorized "failure to cooperate" and European Americans were more likely to appear in the "other" category. The author concluded by discussing practical implications for not only VR counselors, but other related professionals in counseling as well.

Introduction

As researchers continue to debate the reasons racial minority groups encounter more Vocational Rehabilitation (VR) ineligibility than other groups seeking VR services (Atkins & Wright, 1980; Bolton & Cooper, 1980; Feist-Price, 1995; Wheaton, 1995; Wilson, 1997; Wilson, 2002), a consensus accepts that more African Americans tend to have different experiences before they enter human service organizations than European Americans (Atkins & Wright, 1980; Baker & Taylor, 1995; Hacker, 1995; Thomas and Sillen, 1972; Wilson, Harley, McCormick, Jolivette, & Jackson, 2001). As a whole, many of the experiences that racial minorities face prior to entering the VR system are not viewed as positive. African Americans, in particular, seem more likely to have suffered underemployment, unemployment, undereducation, and miseducation than any other ethnic group (Atkinson, Morten, & Sue, 1989; Bennett, 1995). Hacker (1995) provided support for this observation by suggesting that African Americans are more likely to encounter discrimination in educational and vocational areas than other racial and ethnic groups in the United States. Although there are several explanations as to why people tend to be treated differently before they enter human service organizations, one constant seems to be that African Americans and other racial minorities lag behind their European American counterparts in employment and educational opportunities. Further support regarding possible discrimination on people of color is recently provided by Wilson (2002).

Juxtaposed with disability, minority status, particularly African Americans, tends to compound the inequalities certain groups experience before they enter the VR system (Wright &

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Leung, 1993). As Baker and Taylor (1995) reported, "one possible factor among the multifactored environment for African American persons with disabilities is racial [in] combination with disability discrimination" (p. 49). Despite a need for rehabilitation providers to be sensitive to cultural differences between themselves and the customers they serve, too many providers still lack a sensitivity to customers different from themselves, particularity if the counselor is European American and the customer is a person of color (Atkins, 1988; Baker &Taylor, 1995; Dziekan & Okocha, 1993; Wilson et al., 2001).

Meanwhile, as we start the new millennium, the changing U.S. demographics promise to influence population trends and consequently, will influence the future caseload make-up of state-federal VR counselors (Hershenson & McKenna, 1998). The Rehabilitation Act Amendments of 1992 and 1998 underscore the need to accommodate underserved groups seeking VR services (Hershenson, 1988; Wilson, 2000). More recently, if the demographic projects are correct by Henderson (2000), the United States will undergo a demographic transformation that will change the way more health care facilities carry out customer service. For example, the number of Hispanics are projected to triple from 31.4 million in 1998 to 98.2 million in 2050; and the African Americans will increase 34.9 million to 59.2 million during the same time period. Asians and Pacific Islanders and other groups will share similar population increases. Finally, because the initiation of the Individualized Plan for Employment (IPE) has become an essential step in the rehabilitation process in the United States, this article explores what happens to African Americans and European Americans found eligible then subsequently closed without being rehabilitated after an initiation of the IPE (Status 28). Status 28 is the category reserved for customers found eligible for VR services but whose cases were closed unsuccessfully after the initiation of the Individualized Plan for Employment (IPE). Essentially the IPE is a contact between the customer and the VR counselor.

Literature Review

As part of a comprehensive national study in 1980, Atkins and Wright investigated VR case closure patterns among both African Americans and European Americans. They reported race and reason for closure to be statistically significant after customers were accepted for VR services, but whose cases were closed unsuccessfully after the initiation of the IPE. Although statistically significant, Atkins and Wright neglected, however, to specify particular reasons for closure among African Americans and European Americans closed within this Status 28 category.

Following the Atkins and Wright (1980) study, Ross and Biggi (1986) explored access to rehabilitation services at referral while observing outcomes using classification statuses 08 (closed not accepted for VR services), 26 (rehabilitated), 28 (closed for other reasons after the Individual Plan for Employment [IPE]), and 30 (closed for other reasons before the IPE) among African Americans, European Americans, Indians/Alaskans, and Asians and Pacific Islanders. With regard to Status 28 closures, refusal of services emerged as the most cited reason among European American customers for closure when found eligible for VR services, while African Americans were more likely to be closed for failure to cooperate. In rank order (highest to lowest), Ross and Biggi reported (1) refused services (2) unable to locate, (3) failure to cooperate, (4) handicap too severe, and (5) "other" to be the principal reasons noted for Status 28 closures for European Americans. African Americans were more likely to be closed (1) failure to cooperate, (2) unable to locate, (3) refused services, (4) handicap too severe, and (5) other. They also reported that Indians/Alaskans were more likely to be closed for (1) failure to cooperate, (2) handicap too severe, (3) other, and (4) refused services. Finally, Ross and Biggi's research relative to unsuccessful closures among other racial groups revealed that Asians/Pacific Islanders were more likely to be closed (1) unable to locate, (2) handicap too severe, and (3) failure to cooperate. Ross and Biggi failed, however, to produce statistically significant results regarding reasons for unsuccessful outcomes among African Americans and European Americans respectively, once they were accepted and closed in the Status 28 category. From 1980 to 1986, two research teams reported findings regarding Status 28 closures; however, an obvious pattern by race had yet to emerge.

Like Ross and Biggi (1986) before them, Herbert and Martinez (1992) sought to determine whether the ethnicity--Anglo (White) and non-Anglo (Black)--in any way influenced case service outcomes at Statuses 08, 26, 28 and 30. Contrary to prior investigations, albeit inconclusive (Atkins & Wright, 1980; Ross & Biggi, 1986), Herbert and Martinez found no differences between African Americans and European Americans in Status 28 closures. In short, as of 1992, African Americans and European Americans appeared to differ slightly in reasons for closures once IPEs were initiated. Findings regarding Status 28 closures, however, were still inconclusive according to the results of the Herbert and Martinez study.

Three years later, Feist-Price (1995) investigated closures statuses 08, 26, 28, and 30. Feist-Price reported differences in cases "closed for reasons other than successful rehabilitation" (p. 124). Her research, in fact, began to reveal a conceptual pattern based on race. 'Inability to locate,' which Ross and Biggi (1986) had reported as the second reason under the Status 28 closure, appeared to be cited most by African Americans whose cases were closed for reasons other than successful rehabilitation, whereas 'refusing services' was the reason cited most by European Americans. It remained unclear, however, whether the particular results Feist-Price reported belonged in Status 28 or 30 (closure before the initiation of the IPE and after eligibility). Although it was not clear what closure category these results belonged, African Americans and European Americans increasingly revealed different experiences once they were accepted for services.

Finally, in a study that examined participation, progress and outcomes of Nevada VR customers from diverse racial and ethnic backgrounds (namely, African Americans, European Americans, American Indians, Eskimos or Aleuts, Asians or Pacific Islanders, Hispanics, and "others"), Peterson (1996) found no differences between African Americans and European Americans in the Status 28 closure, results similar to what Herbert and Martinez's (1992) reported four year earlier. As these inconsistent findings suggest, reliable research on whether African Americans' and European Americans' experiences differ once members of these groups are accepted for VR services and closed after the initiation of the IPE remains elusive.

The study reported here differs from earlier investigations in two ways: (1) it examines only Status 28 closures and (2) it correlates Status 28 closures by race. An increasing need for accountability now affects such social service organizations as VR with the reauthorization of the Rehabilitation Act and various similar legislative mandates (Hershenson, 1988). Thus, explorations of rehabilitation outcomes continue to attract attention. Moreover, because customer motivation strongly influences VR eligibility and job placement endeavors, practitioners should be able to predict with some certainty who will be VR customers and why these customers disengage from the rehabilitation process after the initiation of an essential part of their overall rehabilitation program has been put in place.

The Research Question

This study examines the following research question: Do African American and European American VR customers whose cases are closed unsuccessfully (Status 28) after their Individual Plans for Employment (IPE) are completed reveal differences in their reasons for closure?

Method

Data Collection

The author drew the data from the Rehabilitation Services Administration (RSA) 911 records that were produced by a state agency where VR counselors recorded the opening and closing of each case. The coding procedures for this RSA-911 data conformed to federal guidelines the RSA established. Since this study relied on archival data, an element of miscoding may have contaminated the collection and the subsequent data analysis. To reduce the possibility of coding errors, however, the RSA has developed 18 crosschecks (RSA, 1995). In any event, the author assigned any coding errors as random and unbiased. Lastly, to decrease the possibility of further coding errors, descriptive statistics were generated and examined for outliers and suspicious patterns. None were observed in the present investigation.

Participants

The population selected included 62,178 customers who sought VR services in a large midwestern state. The subsample included 42,574 African Americans and European Americans who were provided services during fiscal year 1996 (October 1, 1995 through September 30, 1996). The author's first step in this selection process was to identify persons with no missing data on the independent and dependent variables of race and Status 28, respectively. The final subsample included all African Americans (n=115) and European Americans (n=283) with no missing values whose cases were closed unsuccessfully (Status 28).

Variables

Racial/ethnicity status. Racial/ethnicity status is a categorical variable with two levels (African American or European American). "Race" is defined as the race reported by customers on their application for VR services. The author modified the federal labels for race, for example White and Black, to reflect current usage, which tends to include a person's geographical area of origin. Consequently, "Blacks" became African Americans and "Whites" became European Americans. The author excluded Asian Americans and Native Americans because of inadequate sample sizes, which is normal when one uses RSA-911 state databases (see Wheaton, 1995; Wilson, 1997). Presently, a multiracial category does not exist.

Reasons for closure. Reason for closure is a multichotomous variable with 12 levels which are (1) unable to locate, (2) handicap too severe, (3) refused service, (4) death, (5) client institutionalized, (6) transfer to another agency, (7) failure to cooperate, (8) no disabling condition, (9) no vocational handicap, (10) transportation not feasible, (11) client declined order of selection on waiting list, and (12) other.

Test Statistics

Because of the multichotomous independent and dependent variables in the investigation, the Statistical Package for the Social Sciences (SPSS) (1997) recommends both the Chi-square and Cramer's V as the appropriate test statistics. Cramer's V is used when one has other than a 2 x 2 contingency table with categorical variables (SPSS, 1997). The author adopted the Chi-square test of independence to examine the reasons for unsuccessful closures after the initiation of the IPE between African Americans and European Americans. The Adjusted Standardize Residual (ASR) determined whether any cells departed from the null hypothesis of independence. Because the ASR is normally distributed with a mean of 0 and a standard deviation of 1, these scores can be interpreted as z-scores. ASRs of ± 2 are considered statistically significant. Positive ASRs (z-scores) indicated that the proportion of African Americans were greater than European Americans. Negative ASRs (z-scores) indicated that the proportion of European Americans was greater than African Americans (SPSS). The Cramer's V was used to measure the association between the independent and dependent variables.

Results

An initial cross tabulation analysis revealed that the chi-square test violated two of the basic assumptions reported by SPSS (1997) (a cell having less than an expected value of 1 and more than 20% of the cells had expected values of less than 5). Consequently, (4) death, (5) client institutionalized, (6) transfer to another agency, (8) no disabling condition, (9) no vocational handicap, (10) transportation not feasible, and (11) client declined order of selection on waiting were collapsed into the other category. Deleting the aforementioned variables was not considered because data loss would have occurred. Subsequent analysis found no assumption violations in the test statistic.

Race and reason for closure after the initiation of the IPE proved statistically significant: c2 (2, n=398)=11.087; p < .05; Cramer's V=.167. Particularly, 'failure to cooperate' (African Americans) and 'other' (European Americans) were the only cells found to be statistically significant in the cross tabulation table. Table 1 presents the reasons for closure for African Americans and European Americans after the initiation of the IPE.

Table 1

Reasons for Unsuccessful Closure (Status 28) and after the Initiation of the Individual Plan for Employment by Race/Ethnicity

	n (Column Percent) Adjusted Standardize Residual (Status 28)					
	European Americans		African Americans			
	n	(Column %)	n	(Column %)	Total %	ASR
Cannot Locate	20	(7.1)	13	(11.3)	8.3	1.4
Handicap Too Severe	16	(5.7)	4	(3.5)	5.0	-0.9
Refused Service	104	(36.7)	37	(32.2)	35.4	-0.9
Institutionalized	7	(2.5)	2	(1.7)	2.3	-0.4
Failure to Cooperate	73	(25.8)	44	(38.3)	29.4	2.5*
Other	63	(22.3)	15	(13)	19.6	-2.1*
Total	283	(100)	115	(100)	(100)	

* $p < .05$. Note. χ^2 (2, n=398)=11.087; $p < .05$; Cramer's V=.167. Positive z-scores indicate that the proportion of African Americans were greater than the proportion of European Americans. Negative z-scores indicate that the proportion of European Americans were greater than the proportion of African Americans.

Discussion

The results of this study confirm that race and reason for closure after the initiation of the IPE was statistically significant and only slightly associated. These results challenge the results reported earlier by Herbert and Martinez (1992) and Peterson (1996), who found no consistent differences in unsuccessful closures after the initiation of the IPE among African Americans and European Americans with disabilities. The results of this investigation do, however, conform to the conclusions of Atkins and Wright (1980) and Feist-Price (1995) who found race and Status 28 closures generally dependent (statistically significant) from each other. Interestingly enough, 'failure to cooperate' materialized as a primary reason why African Americans are closed after the initiation of the IPE. Similarly, 'failure of cooperate' was also the primary reason for closure for African Americans after the initiation of the IPE in the Ross and Biggi (1986) study. On the other hand, European Americans appear more likely to be closed for 'other' reasons. Because the author collapsed seven variables into the 'other' category to maintain chi-square assumptions, there is no definite explanation for unsuccessful closures for European Americans after the initiation of the IPE emerged in this investigation. In fact, the futility here increases when one analyzes earlier findings, virtually all of which failed to produce clear patterns among European Americans for unsuccessful closure after the initiation of the IPE. This obvious knowledge gap signals a need for additional research in this vital area of VR outcomes; however, given that a pattern appears to emerge for African Americans unsuccessfully closed in the VR system, namely 'failure to cooperate' once African Americans are accepted and have initiated the IPE, the author will explore possible explanations for the 'failure to cooperate' closure pattern among African Americans with disabilities in the VR system.

Herbert and Martinez (1992) suggested four considerations for understanding customer outcomes: (1) the customer's culture may be misunderstood by the counselor; (2) the assessment phase may indicate values opposite from the societal norm; (3) the counselor may ignore a customer's experiences during the counseling session; or (4) all of these. To help customers who possess different racial and ethnic backgrounds, vocational rehabilitation providers must remain open to new ways of assessing potentially biased attitudes within themselves. Adopting this attitude, they can expect more understanding among customers from diverse backgrounds, which will eventually improve the experiences of African Americans and people of color in the VR system. Recently, Wilson et al. (2001) adduced that understanding the cultural backgrounds of racial minorities may improve the experiences of racial minorities within the VR system.

The assessment theme Herbert and Martinez presented in 1992 appears promising because much of what is documented in an IPE may be guided by such assessments before the IPE write-up, including customers who may consider themselves unfairly evaluated and directed. In any event, disgruntled customers may decline to cooperate with the VR counselor once the IPE is completed, resulting in Status 28 closures, after they were accepted for VR services. This illustration appears congruent with the results found in this investigation if one looks at the apparent discrepancy in termination rates between African Americans and European Americans, as Sue and Sue reported in 1990. Worldview may be considered when one looks at the discrepancies of the majority cultural and racial and ethnic minorities. "Ethnocentrism, or the belief that one's worldview is reality, has pervaded human history" (Dana, 1998, p. 23). More recently, Mahalik, Worthington, and Crump (1999) revealed that racial minorities tend to have different worldviews than therapists' (African Americans and European Americans). Additionally, Mahalik et al. adduced that this worldview tends to be most like that of the European American middle class. For the African American customer, the 'failure to cooperate' theme reported in both the present and prior investigations seems problematic, especially when viewed in the present context of potentially differing worldviews for both customers and counselors within the VR system. Perhaps, African Americans are being closed 'failure to cooperate' because their worldview is different than the VR counselor, and that these different worldviews will inherently create a certain level of stress within the customer-counselor dyad. Of course, it is more productive for the customer-counselor dyad to work through any misunderstandings to produce a favorable outcome, not only for African American customers in the VR system, but for all customers within the VR system. Being open and realizing one's biases and stereotypes are only two ways to start this most important therapeutic counseling process. As Dana (1998) recently asserted: "It is now politically correct to assert that cultural sensitivity is necessary because multicultural clients may be found in any service delivery setting, and consequently an openness to new cultural learning is required" (p. 15). Assessment bias may be another reason for the apparent difference for Status 28 closure between the two groups.

As Baker and Taylor (1995) reported, "Multiple opportunities for assessment bias to underestimate the work potential of the African American person with a disability may be present in the evaluation part of the first phase" (p. 46). In 1988, a study by Geller reported that after using identical patient data except for race and I.Q., that African American patients were rated less able to benefit from psychotherapy, as opposed to European American patients. While the potentially biased VR counselor may reflect rehabilitation counseling professionals relying on Eurocentric evaluation instruments and intervention approaches and on previously held negative or positive stereotypes about various diverse customers, special attention to assessment protocols is warranted. For example, assessment instruments may reflect the values and beliefs of the majority and underrepresent the values and beliefs of other cultures and backgrounds (Cayleff, 1986; Pape, Walker, & Quinn, 1983; Pedersen, 1991; Sue, Arredondo, & McDavis, 1992; Walker, 1991; Wright, 1988). As Frey (1984) noted, "All of what we do in rehabilitation depends upon our abilities to make appropriate, reliable, and valid assessments of those variables that facilitate the rehabilitation process. These assessments serve as a basis for all professional activity" (p. 12). Unnecessarily negative results will contaminate the appraisal process if counselors remain unaware of societal influences on themselves and on VR customers. Those who assess African Americans with disabilities must employ a variety of techniques aimed at including them in the rehabilitation process (Atkins, 1988). In particular, Parham (2002) recently mentioned strategies to facilitate the counseling process with African American clients. Alston and Mngadi (1990) suggested that a major responsibility for rehabilitation professionals is client placement, and an assessment of the customer's vocational potential. Therefore, in the phrasing of Gordon and Hsia (1994), "Lack of awareness and skill in evaluating clients of differing cultural backgrounds may hinder the ability to provide accurate information. It is critical that all rehabilitation professionals recognize the cultural implications for service provision" (p. 40). Lastly, communication between the customer and the counselor promotes an accurate and realistic appraisal of the appropriateness of stated goals written in the IPE. In other words, facilitating openness can lead to the overcoming of harmful stereotypes between racial minorities with disabilities and rehabilitation providers.

Limitations of the Study

Because this study used archival data, an obvious weakness appears in the non-manipulation of the independent variable within the investigation. The only variables the author controlled for were race and Status 28 closures, a condition that might also limit the generalizability of the results. While the author feels confident in generalizing the results to the state the data was collected, other researchers in other states might usefully replicate this investigation to see whether their results conform to the results reported in the present study.

Future Research

Variables uncontrolled for in this investigation included education, disability severity, and customer earnings, to name only a few. Future research might want to control for other variables to see whether outcomes remain consistent across region, if a national database can be employed. Because the preponderance of past research into Status 28 closures primarily drew upon African Americans and European Americans for samples, future research might include additional races in the research design to see whether outcomes appear to differ by race. Although their results appeared to lack statistical significance, Ross and Biggi (1986) observed that after that the initiation of the IPE, most groups were closed for similar reasons. Nevertheless, a consistent pattern may emerge regarding Status 28 closures, particularity for European Americans with disabilities. The author suggests, however, that including additional racial ethnic groups in the use of RSA-911 data may be more difficult than it sounds. For example, the reason other racial and ethnic groups were absent from the present investigation was the severely limited number of, for example, Asian customers in the RSA-911 database, a practical consideration that may hinder expanded inquiries focused on the inclusion of other groups. Conceivably, the changing demographics may eventually increase the inclusion of other racial ethnic groups in research employing the RSA-911 database, but that opportunity seems unlikely to appear soon.

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The Journal of the Pennsylvania Counseling Association/Volume 5, Number 2 Summer2003

Campus Wide Alcohol Use Compared to Students Seeking Counseling Services

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From a sample of 350 college students, drinking patterns of students seeking counseling services were compared to those in the general student population. No significant difference was found between the counseling services group and the general student population regarding heavy versus light drinking. Overall, no significant difference was found between males and females regarding heavy versus light drinking within both the counseling services group and the general student population. The general student population, when examined as a whole, revealed significantly more heavy drinkers than light drinkers. The results suggest that alcohol use among college students seeking counseling services may not differ from the general student population. Therefore counselors and administrators in college and university settings may need to further investigate appropriate approaches for addressing alcohol issues with their clients.

This study was supported in part by a grant from the Fund for the Improvement of Post Secondary Education through the U.S. Department of Education.

The prevalence of heavy drinking on college campuses has been well documented (Wechsler & Kuo, 2000; Presley, Millman & Cashin, 1996; Perkins, 1995; Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994; Johnston, 1992) with current research indicating a rise in alcohol abuse among 4-year college students. This research reports that up to 31.6% of college students meet DSM-IV diagnostic criteria for alcohol abuse, and 1 out of every 20 college students participates in behaviors consistent with a 12 month diagnosis of alcohol dependence (Knight, Wechsler, Kuo, Seibring, Weitzman, & Schuclit, 2002). Recent surveys also confirm drinking rates as profiled by gender; heavy drinking is higher among male students as compared to female students, with prevalence at 50% and 33% respectively (O'Malley & Johnston, 2002).

Although alcohol use has been significantly correlated with a wide variety of mental health issues (Kessler, Crum, Warner, Nelson, Schulenburg, & Anthony, 1997), few researchers have begun to investigate the unique relationships between alcohol use and co-occurring mental health problems among college students. O'Hare and Sherrer (2000) examined associations between co-occurring stress and substance abuse behavior, verifying significant comorbid relationships. Colder (2001) found that college students with higher rates of "negative emotionality" are at a greater risk of self-medicating. Other research points to drinking rationale, behavior, environment, and pre-collegiate characteristics which influence drinking patterns (Knight et al., 2002). Still, no research was found that specifically looked at co-occurrence between specific disorders and alcohol disorders among a sample of college students.

However, there have been national research initiatives such as the National Comorbidity Study (NCS) and the Epidemiologic Catchment Area (ECA) study, which detail the prevalence of comorbidity between DSM-III-R mental disorders and alcohol disorders among general populations, as well as the British Psychiatric Morbidity Survey (BPMS), which assessed data obtained and evaluated using the Clinical Interview Schedule – R (CIS-R). Kessler, Nelson, McGonagle, Edlund, Frank, and Leaf (1996) present compelling comorbid associations gathered from NCS figures. Of respondents, 33% with an alcohol abuse disorder and 45% with an alcohol dependence disorder had at least one other co-occurring mental health disorder diagnosis. Analysis of earlier ECA data shows 47% of individuals classified as having alcohol abuse / dependence problems had other co-occurring mental health disorders (Helzer & Pryzbeck, 1988). Also, when comparing BPMS subjects, Farrell, Howes, Bebbington, Brugha, Jenkins, Lewis, Marsden, Taylor, and Meltzer (2001) classified 30% of alcohol dependent individuals as having another co-occurring psychiatric disorder and determined that alcohol dependence was most prevalent among those classified as a 'heavy drinker.'

Furthermore, Tsuang, Crowley, Ries, Dunner, and Roy-Byrne (1995) suggest that half of those diagnosed with anxiety disorders or depression have coexisting (and frequently hidden) substance use disorders. Decker and Ries (1993) and Miller (1994) found that most depressed individuals with alcohol abuse problems are free of depressive symptoms within 2-5 weeks of abstinence. Also Beaty and Cipparrone (1993) discovered that most men diagnosed with depression, anxiety, and obsessive compulsive disorders along with co-occurring alcohol abuse, no longer met DSM-III-R criteria for their psychiatric diagnoses after four weeks of alcohol abstinence. Earlier work suggests that individuals assessed with anxiety problems, impulse control problems, self-destructive ideation, and social skills deficits had underlying alcohol abuse issues (Scaturo & LaSure, 1985).

Gender differences among individuals show that alcohol dependent females were more likely to be appraised as having co-occurring psychiatric disorders than males (Farrell et al., 2001; Kessler, McGonagle, Xhao, & Nelson, 1994). All lifetime co-occurring alcohol abuse / dependence and lifetime NCS / DSM-III-R disorders diagnoses were higher among females, except for conduct disorder, adult antisocial behavior, and antisocial personality disorder (Kessler et al., 1997). Helzer and Pryzbeck (1988) report a 44% comorbid rate among male alcoholics as opposed to a 65% comorbid rate among females. Pettinati, Rukstalis, Luck, Volpicelli, and O'Brien (2000) found 'years of alcohol use' to be a significant covariate for gender and comorbidity. Gender differences among college students show that males report drinking to relieve social anxiety, while females report drinking to relieve emotional pain (Thombs, 1993). Although different in rationale, both illustrate attempts to self medicate.

Furthermore, individuals with co-occurring alcohol and other mental health diagnoses utilize services at higher rates than single disorder diagnosed individuals (Wu, Kouzis, & Leaf (1999). Kessler et al. (1996) found that alcohol dependent respondents utilized mental health services at a rate of 19% whereas comorbid respondents utilized services at a rate of 41.2%. This co-occurrence or comorbidity is often referred to as a "dual diagnosis," which "denotes individuals in whom a psychiatric disorder(s) and a substance abuse problem(s) *coexist* and *are equally important, independent disorders*" (Doweiko, 2002, p. 271). Occasionally the term dual diagnosis is used more loosely and may include alcohol disorders which co-occur with problems like spousal abuse or AIDS (Doweiko, 2002). However many researchers abide by a definition that includes the diagnosis of a separate psychiatric illness (Phillips & Johnson, 2001).

Understanding the elevated rates of co-occurrence associated with alcohol disorders becomes meaningful when planning prevention strategies, during assessment, and throughout treatment - especially when service is confounded by approaches that neglect to address the idiosyncrasies of comorbidity (Modesto-Lowe & Kranzler, 1999) or result in misdiagnosis. In their study of over 200 clients diagnosed with alcohol use disorders or depression, Hanna and Grant (1997) found that women diagnosed with depression frequently have an undiagnosed alcohol problem and that men diagnosed with alcohol use disorders frequently have undiagnosed major depression. Clinicians need to routinely consider and account for possible comorbidity (Kessler et al., 1996).

With this review of the literature, the following patterns emerge: alcohol abuse among college students continues to be a problem, mental health problems and alcohol abuse are associated, co-occurrence between mental health problems and alcohol problems is greater among females than males, and the presence of multiple mental health disorders increases service utilization. It is believed that these patterns will also be seen among a college student population. In particular it is hypothesized: (a) proportionally, the number of college students classified as heavy alcohol users will be greater among students who utilize university counseling services as compared to the general student population; (b) more males than females will be classified as 'heavy drinkers' in the general student population; (c) because of higher comorbidity rates among women, and higher service utilization rates among comorbids, there will be no difference between male and female's heavy alcohol use among students who utilize university counseling services.

Method

Instrument

The "Core Alcohol and Drug Survey, Long Form" (Presley et al., 1996) was utilized. The "Core Alcohol and Drug Survey, Long Form" is a self-administered questionnaire that includes questions measuring demographic characteristics; use of alcohol, tobacco, and other drugs; perceptions of student and campus norms about alcohol and drug use; problems associated with alcohol and drug use; and expectancies about alcohol. Content-related validity for the Core survey has been reported at .90 with test-retest reliability at .89 (Presley et al., 1996) showing it to be a stable, reliable instrument.

Procedure and Sampling

Undergraduates at a medium sized, urban, doctoral granting university in the South were surveyed. This university is a typical urban commuter institution.

The "Core Alcohol and Drug Survey, Long Form" (Presley, et al., 1996) was administered to students in the general population using a stratified cluster sample of classes at the beginning of the Spring semester. Clusters were identified by developing a two-way matrix of classes reflecting the proportion of students in each year and college. Individual classes representative of each cell (e.g., sophomore engineering students) were selected. All students were informed of the anonymous and voluntary nature of the survey. 655 surveys were distributed, completed, and returned during class. All surveys were returned. The sample was found to match the university population on ethnic origin, gender, class, and college.

During the same semester, surveys were completed using intake data from all students who presented for counseling at the university's office of counseling services. The intake form used in this service contained a self-report alcohol and other drug survey patterned after the "Core Alcohol and Drug Survey, Long Form" survey, as well as relevant demographic data. A total of 175 cases contained sufficient information to complete the surveys. Only students presenting for mental health related issues were included in this data set (the most frequent presenting problems were relationship issues and depression).

The final sample of 350 participants included 175 students randomly selected from the general student population data set and the 175 students from the counseling population data set. Due to missing data the number used in each analysis varies slightly. The two groups were similar on most demographic characteristics. They did not differ on age. The mean age for the total sample was 25.30, with a range of 17 to 56. The groups did not differ in ethnic origin (72% white, 13.3% African American, and 5.6% Asian), or in employment (59% worked full or part-time). There were a higher number of freshmen in the general population, more sophomores and juniors in the counseling group, and significantly more females in the counseling population.

Results

Based on responses to question 17b "Within the last year about how often have you used...Alcohol (beer, wine, liquor)" students were categorized into either a light drinking category (never to twice a month) or heavy drinking (weekly to daily). This dichotomous variable was used as the dependent measure. Independent variables were group (counseling vs. general population) and gender. This approach was taken because the response options on the Core survey are categorical (with the exception of one response to "number of drinks per week"). Therefore Chi-square comparisons were made for: (a) group by level of drinking for the entire population, (b) gender by level of drinking for the general student population, and (c) gender by level of drinking for counseling services students only. Individual comparisons were then made between cells when significant differences were indicated.

Hypothesis A

The number of college students classified as heavy alcohol users will be greater among students who utilize university counseling services as compared to the general student population - was not supported. However, the overall chi-square was significant (see Table 1). Further analysis indicates that although there is no difference in classification among the counseling population (X2 (1, N=168) = .595), or between the counseling group and the general population in either light drinking (X2 (1, N=161) = 1.795) or heavy drinking (X2 (1, N=182) = 3.165), the general population has significantly more heavy drinkers than light drinkers, X^2 (1, N=175) = 5.49, p=.019.

Table 1

Gender by level of drinking for the entire college population

		Frequency of Light drinkers	Frequency of Heavy drinkers
Counseling	Observed	89	79
	Expected	78.9	89.1
General population	Observed	72	103
	Expected	82.1	92.9

Pearson X^2=4.819, df=1, p=.028

Hypothesis B

More males than females will be classified as 'heavy drinkers' in the general student population – was not supported; no significant difference was found between males and females in heavy versus light drinking.

Table 2

Gender by level of drinking for the general student population

		Frequency of Light drinkers	Frequency of Heavy drinkers
Males	Observed	29	47
	Expected	31.8	44.2
Females	Observed	40	49
	Expected	37.2	51.8

Pearson X^2=.776, df=1, p=.378

Hypothesis C

There is no difference between the number of males and females classified as heavy drinkers among students who utilize university counseling services – was supported (see table 3).

Table 3

Gender by level of drinking for counseling service students

		Frequency of Light drinkers	Frequency of Heavy drinkers
Males	Observed	22	30
	Expected	27.5	24.5
Females	Observed	67	49
	Expected	61.5	54.5

Pearson X^2=3.44, df=1, p=.064

Discussion

Although it was hypothesized that the group seeking counseling would have more heavy drinkers, no difference was found between the counseling services population and the general student population. It was predicted that the hypothesized disparity between male and female student's heavy alcohol use in the general student population would not be present among students who utilize university counseling services. This hypothesis was supported. However, there was no difference between male's and female's heavy drinking in the general student population as found in previous studies. This makes support of the final hypothesis difficult to interpret.

It should be noted that although females did not differ significantly from males in heavy drinking group membership, neither did males differ from females in light drinking group membership. This is contrary to popular perceptions of consumption. Surprisingly, a high percentage of males were in the light drinking group.

Wechsler and Isaac (1992) noted an increase in abstinence both in males and females as well as a drinking pattern that follows a more infrequent heavy drinking course. When Perkins (1992) looked at perceptions of the distribution of drinking patterns for men and women on college campuses, he found that most people perceive a distribution skewed toward light drinking for women and toward heavy drinking for males. Although this perception is relatively accurate for females it is not accurate for males. In fact males' drinking patterns tended to fall into a bi-modal distribution in his study, with males' and females' distributions parallel except for a second peak on the heavy drinking end for the males.

It seems likely that alcohol use within a college population is different than use within the general population. If that is so, common models of explanation, prevention, and treatment may not be applicable. Perkins (1995), looking at reasons for drinking, found that college drinking occurred more for social reasons while post college drinking was more for stress relief. Furthermore, Wechsler and Isaac (1991) found general behavior discrepancies; college students partake in higher risk drinking behavior yet have a lower prevalence of smoking, are less likely to be overweight, and use seatbelts more often than non-college cohorts.

It is possible that there is a much broader mythology of "the college student" that influences drinking behavior, roles, and norms than typically considered. The development and maintenance of this mythology goes far beyond the individual student's drinking behavior to the organization and attitudes of the larger group, culture, and system. Drinking behavior has not only become socially acceptable within the college culture but also attractive. Wechsler et al. (1994) noted that alcohol has traditionally held a unique place in campus life, suggesting that colleges may create and unwittingly perpetuate drinking cultures through selection, tradition, and policy. Both Perkins (2002) and Treise, Wolburg, and Otnes (1999) described a collegiate drinking culture that has created rituals around drinking where the influence of social norms maintain a perceived status quo.

Becvar and Becvar (1993) suggested that humans construct reality through stories, and in fact, history can be viewed as a story. This is similar to May's (1991) discussion of myth around which humans pattern their lives. The fact that few students identify themselves as having a drinking problem (Wechsler et al., 1994) may be considered "denial" in other mythologies (traditional treatment models); however, it may be behavior consistent with campus norms (or storied reality). Wechsler and Kuo (2000) found that what most clinicians would define as high risk drinking is not viewed as abnormal by the majority of college students. Students consider higher risk drinking behavior, which outside of the university community would be seen as problematic, as normal within their context or "culture." The students are personifying the role of "college student" and behaving appropriately as handed down through an oral history. They are following tradition and partaking in ritual. Thus, prevention programs that target the individual are not likely to succeed.

Implications for Professional Practice

Sue and Sue (2003) have written extensively on the need to understand the client's worldview prior to proceeding with counseling. Although they apply this principle to counseling clients from racial or ethnic minorities, understanding a client's worldview seems relevant when counseling the heavy drinking college student. It can be argued that college students live in a culture separate from the mainstream, especially related to the use of alcohol. Within the myths, norms, and oral history of the "college culture" the heavy use of alcohol is accepted, and at times expected. Vik, Culbertson, and Sellers (2000) in a study of stages of change (Prochaska & DiClemente, 1983) applied to heavy drinking college students found that only 13% of college students who drank heavily were in the action stage, and over two thirds were in the precontemplation stage. Again, these findings would lend credence to the idea of heavy drinking being "normal" within the cultural context. Clearly some intervention is needed. However, the nature of this intervention given the campus culture is less clear.

Even if identified as heavy drinkers, college students do not seem to be motivated to change. Wolfson (2000) has linked this lack of motivation to students' overestimation of alcohol use among peers, and their own use to be normal in the context of commonality. Steenbarger (1998), in a review, applies a disease metaphor to describe alcohol problems on campus. However, the consistent finding that after college most students return to drinking patterns parallel to their non-college peers implies that most of these heavy drinkers are not alcohol dependent. If one accepts this assumption, it would seem that classical approaches to problem drinking (e.g., mainstream 12-Step based treatment) would yield less than optimal results on a college campus.

It may be that practitioners need to be more proactive in influencing social norms (i.e., storied realities) in the campus culture. Perkins (2002) and DeJong (2002) argue that prevention efforts need to focus on communicating a more accurate picture of actual student drinking attitudes in order to reduce the overestimation of alcohol use that many students have with regard to their peers. Both maintain that "Social norm campaigns" and advocacy efforts challenge the status quo of the college culture by providing students with an alternative and more accurate frame of reference, and these efforts work toward recreating college rituals. As Steenbarger (1998) suggests, counseling services also need to do a better job assessing alcohol use on all students presenting for counseling. However, treatment for those who present with alcohol problems may best be approached from a model that incorporates the storied realities of the campus culture. The Solution Focused model (Berg & Miller's, 1992; Berg & Ruess 1998) is an example of one such approach. This model shifts focus from a disease/problem orientation to one that capitalizes on clients' unique outcomes and successes. This approach and others based on an epistemology that incorporates a social constructivist view may work well within the student's storied reality.

Limitations and Recommendations for Future Research

This research is clearly limited by the nature of the instrument. The categorical variables in the Core survey prevent the investigation of actual differences in levels of drinking between the general population and those seeking counseling services. In addition, because the data collected on the counseling population was archival in nature (transcribed from intake forms), it limited the number of variables that could be considered in the comparison between populations (e.g., perception of others' use, reasons for their own use).

Alcohol use is an extremely important issue for counselors to address in college and university settings. Not only are these counselors facing students with alcohol use intertwined with other presenting issues but they are often called upon to lead prevention efforts on campus. While there has been an emerging body of knowledge on overall college student alcohol use, there is little research available to guide counselors on working with clients in this setting. Further research needs to be done investigating what role alcohol plays for this unique client population and how these clients' use of alcohol may differ from a non-college cohort as well as other college students not seeking counseling services.

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The Journal of the Pennsylvania Counseling Association (ISSN 1523-987X) is a biannual publication for professional counselors. It is an official, refereed branch journal of the American Counseling Association, Inc.

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EFF-089 (1/2003)